SERFF Tracking Number:	*MRKC-128177674*	*State:*	*District of Columbia*
Filing Company:	*Markel Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*MSTM200-DC (11/11)*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*Short Term Medical Amendatory Endorsement*		
Project Name/Number:	*MSTM200-DC (11/11)/MSTM200-DC (11/11)*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
	Rate Manual	MSTM100 et. al.	Revised	Previous State Filing Number: Percent Rate Change Request:	Markel STM RM - Med Pay 20110923.pdf

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Experience Rating Methodology

Partial credibility may be applied to a new program that has prior experience with a similar product or to an existing segment of the short-term medical block of business (such as business sold through multiple distribution sources).

To apply partial credibility, the historical claims experience would be trended, normalized, and loaded for expenses, using the pricing target loss ratio, to arrive at an indicated premium rate (PI).

The rate manual age, gender, plan, and zip code factors would be used to normalize the experience.

The indicated premium rate would be weighted with the manual premium rate (PM) based on the credibility factors (CF) below to produce a credibility weighted premium (PW).

PW = PI x CF + PM x (1 - CF)

Issued Policies	Credibility Factor
0-4,999	0%
5,000-9,999	15%
10,000-14,999	30%
15,000-19,999	45%
20,000-24,999	60%
25,000-29,999	70%
30,000-34,999	80%
35,000-39,999	90%
40,000 and up	100%

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Premium Rate Algorithm				
Step 1.	Payment option		Single Payment	Monthly Payment
Step 2.	Daily Adult Rate			
	Applicant			
	Spouse	+	Table 1	
	Subtotal	=		
Step 3.	Daily Child Rate			
	Per child rate		Table 1	
	Number of children	x		
	Subtotal	=		
Step 4.	Subtotal Daily Rate	=	Step 2 + Step 3	
Step 5.	Intensive Care Adjustment	x	Table 2	
Step 6.	Plan Option Adjustment	x	Table 3	
Step 7.	Zip Code Factor	x	Table 4	
Step 8.	Medical and Experience Trend Factor	x	Table 5	
Step 9.	Payment Option Factor	x	1.0	1.2
Step 10.	Number of Days of Coverage Single - 30-185 days Monthly - actual number of days in each month	x		
Step 11.	Total Premium Before Fees	=	Step 4 x Step 5 x Step 6 x Step 7 x (1 + Step 8) x Step 9 x Step 10	

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Table 1 - Base Daily Rates

Age	Male	Female
00-24	1.54	1.73
25-29	1.64	2.04
30-34	1.73	2.35
35-39	2.20	2.75
40-44	2.60	2.99
45-49	3.06	3.51
50-54	4.60	4.31
55-59	6.33	5.36
60-64	9.08	6.40
Per Child	0.90	0.90

Table 2 - Intensive Care Limit Adjustment Factors

Multiple of Average Semi-Private Room Rate	Adjustment Factor
1	0.97
2	0.98
3	1.00

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Table 3 - Plan Option Adjustment Factors

A. 100% of Medicare Payment Levels

Deductible per Coverage Period

0-93 Days of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.124	1.066	0.921	0.672
90%	3.220	1.975	1.506	1.046	1.012	0.871	0.647
80%	2.863	1.772	1.332	0.950	0.892	0.776	0.581
70%	2.577	1.593	1.207	0.855	0.801	0.705	0.515
60%	2.353	1.456	1.104	0.780	0.747	0.635	0.469
50%	2.129	1.328	1.004	0.705	0.676	0.585	0.427

94 Days - 6 Months of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.257	1.174	1.029	0.755
90%	3.577	2.203	1.664	1.178	1.120	0.954	0.705
80%	3.183	1.954	1.490	1.058	1.000	0.859	0.639
70%	2.859	1.772	1.340	0.959	0.905	0.788	0.577
60%	2.631	1.614	1.232	0.863	0.809	0.718	0.531
50%	2.373	1.456	1.108	0.788	0.739	0.647	0.485

Deductible per Cause

0-93 Days of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	0.971	0.913	0.772	0.552
90%	3.124	1.884	1.369	0.917	0.859	0.743	0.527
80%	2.801	1.680	1.224	0.842	0.768	0.651	0.461
70%	2.515	1.523	1.120	0.747	0.693	0.602	0.415
60%	2.290	1.390	1.017	0.693	0.643	0.552	0.394
50%	2.100	1.261	0.938	0.622	0.593	0.506	0.349

94 Days - 6 Months of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.079	1.000	0.855	0.589
90%	3.448	2.066	1.527	1.025	0.946	0.805	0.564
80%	3.087	1.863	1.357	0.905	0.851	0.734	0.502
70%	2.797	1.680	1.228	0.830	0.780	0.664	0.456
60%	2.539	1.548	1.124	0.759	0.726	0.614	0.432
50%	2.311	1.390	1.046	0.705	0.656	0.564	0.386

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Table 3 - Plan Option Adjustment Factors

B. 110% of Medicare Payment Levels

Deductible per Coverage Period

0-93 Days of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.191	1.129	0.979	0.718
90%	3.394	2.083	1.593	1.112	1.075	0.925	0.693
80%	3.021	1.871	1.411	1.008	0.950	0.826	0.622
70%	2.722	1.685	1.278	0.909	0.851	0.751	0.552
60%	2.485	1.544	1.174	0.830	0.797	0.680	0.506
50%	2.257	1.407	1.066	0.751	0.722	0.627	0.456

94 Days - 6 Months of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.332	1.245	1.091	0.805
90%	3.768	2.328	1.759	1.249	1.187	1.017	0.755
80%	3.357	2.062	1.577	1.124	1.062	0.917	0.685
70%	3.017	1.871	1.419	1.021	0.963	0.842	0.618
60%	2.780	1.710	1.311	0.917	0.863	0.768	0.568
50%	2.515	1.548	1.178	0.842	0.788	0.693	0.523

Deductible per Cause

0-93 Days of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.029	0.967	0.822	0.589
90%	3.290	1.988	1.448	0.971	0.913	0.788	0.560
80%	2.954	1.776	1.295	0.892	0.813	0.693	0.494
70%	2.656	1.614	1.187	0.793	0.739	0.643	0.448
60%	2.423	1.473	1.079	0.739	0.685	0.589	0.419
50%	2.224	1.340	0.996	0.664	0.635	0.539	0.373

94 Days - 6 Months of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.145	1.062	0.913	0.631
90%	3.631	2.183	1.614	1.087	1.004	0.859	0.606
80%	3.257	1.967	1.436	0.963	0.905	0.784	0.535
70%	2.950	1.780	1.303	0.884	0.830	0.710	0.490
60%	2.685	1.639	1.195	0.805	0.776	0.656	0.465
50%	2.448	1.477	1.112	0.751	0.701	0.606	0.415

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Table 3 - Plan Option Adjustment Factors

C. 120% of Medicare Payment Levels

Deductible per Coverage Period

0-93 Days of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.257	1.195	1.033	0.763
90%	3.560	2.191	1.676	1.170	1.137	0.979	0.734
80%	3.170	1.967	1.485	1.066	1.004	0.876	0.660
70%	2.859	1.772	1.349	0.959	0.900	0.797	0.589
60%	2.618	1.627	1.237	0.880	0.846	0.722	0.539
50%	2.378	1.485	1.124	0.797	0.768	0.668	0.490

94 Days - 6 Months of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.402	1.315	1.154	0.855
90%	3.950	2.444	1.851	1.320	1.257	1.075	0.805
80%	3.523	2.170	1.660	1.187	1.124	0.971	0.730
70%	3.170	1.971	1.498	1.079	1.021	0.892	0.656
60%	2.925	1.801	1.382	0.971	0.917	0.813	0.606
50%	2.651	1.631	1.245	0.892	0.834	0.734	0.556

Deductible per Cause

0-93 Days of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.083	1.021	0.867	0.627
90%	3.452	2.087	1.527	1.025	0.967	0.834	0.598
80%	3.100	1.867	1.361	0.946	0.863	0.734	0.523
70%	2.788	1.697	1.249	0.838	0.784	0.680	0.473
60%	2.548	1.552	1.141	0.784	0.726	0.627	0.448
50%	2.344	1.411	1.054	0.705	0.672	0.573	0.398

94 Days - 6 Months of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.207	1.120	0.963	0.672
90%	3.809	2.290	1.701	1.149	1.062	0.909	0.643
80%	3.419	2.066	1.510	1.017	0.959	0.830	0.568
70%	3.104	1.871	1.373	0.934	0.876	0.751	0.519
60%	2.822	1.726	1.261	0.855	0.822	0.697	0.494
50%	2.581	1.556	1.174	0.797	0.743	0.643	0.444

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Table 3 - Plan Option Adjustment Factors

D. 130% of Medicare Payment Levels

Deductible per Coverage Period

0-93 Days of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.324	1.257	1.095	0.809
90%	3.730	2.299	1.763	1.237	1.199	1.037	0.780
80%	3.328	2.066	1.564	1.124	1.062	0.925	0.701
70%	3.004	1.863	1.423	1.012	0.954	0.846	0.627
60%	2.751	1.714	1.307	0.929	0.896	0.763	0.573
50%	2.506	1.564	1.191	0.842	0.813	0.705	0.519

94 Days - 6 Months of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.477	1.386	1.220	0.909
90%	4.141	2.564	1.946	1.390	1.328	1.137	0.855
80%	3.697	2.278	1.747	1.253	1.191	1.029	0.776
70%	3.332	2.075	1.577	1.141	1.079	0.946	0.697
60%	3.079	1.896	1.461	1.029	0.971	0.863	0.643
50%	2.793	1.718	1.315	0.942	0.884	0.780	0.593

Deductible per Cause

0-93 Days of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.141	1.079	0.917	0.664
90%	3.618	2.191	1.606	1.083	1.021	0.884	0.635
80%	3.253	1.959	1.436	0.996	0.913	0.776	0.556
70%	2.929	1.784	1.320	0.888	0.830	0.722	0.506
60%	2.680	1.635	1.203	0.830	0.772	0.664	0.477
50%	2.469	1.490	1.112	0.747	0.714	0.610	0.427

94 Days - 6 Months of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.270	1.183	1.017	0.710
90%	3.992	2.407	1.788	1.212	1.120	0.959	0.685
80%	3.585	2.174	1.589	1.075	1.012	0.876	0.606
70%	3.257	1.967	1.448	0.988	0.929	0.797	0.552
60%	2.971	1.817	1.332	0.905	0.871	0.739	0.527
50%	2.718	1.643	1.241	0.842	0.788	0.685	0.473

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Table 3 - Plan Option Adjustment Factors

E. 140% of Medicare Payment Levels

Deductible per Coverage Period

0-93 Days of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.390	1.324	1.154	0.855
90%	3.905	2.407	1.851	1.299	1.261	1.091	0.826
80%	3.485	2.166	1.643	1.183	1.120	0.979	0.743
70%	3.145	1.954	1.494	1.066	1.004	0.892	0.664
60%	2.888	1.801	1.373	0.979	0.946	0.805	0.606
50%	2.631	1.647	1.253	0.892	0.859	0.747	0.552

94 Days - 6 Months of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.556	1.461	1.286	0.959
90%	4.332	2.689	2.041	1.465	1.398	1.199	0.905
80%	3.871	2.390	1.834	1.320	1.253	1.083	0.822
70%	3.494	2.174	1.656	1.199	1.137	0.996	0.739
60%	3.232	1.992	1.535	1.083	1.025	0.913	0.685
50%	2.934	1.809	1.386	0.996	0.938	0.826	0.627

Deductible per Cause

0-93 Days of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.199	1.137	0.963	0.701
90%	3.788	2.295	1.685	1.137	1.075	0.934	0.672
80%	3.407	2.054	1.506	1.050	0.959	0.822	0.589
70%	3.071	1.871	1.386	0.934	0.871	0.759	0.535
60%	2.813	1.718	1.266	0.871	0.813	0.701	0.506
50%	2.593	1.564	1.174	0.788	0.755	0.643	0.452

94 Days - 6 Months of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.336	1.245	1.071	0.751
90%	4.178	2.519	1.876	1.274	1.183	1.012	0.722
80%	3.755	2.278	1.672	1.129	1.066	0.925	0.643
70%	3.415	2.066	1.523	1.041	0.979	0.838	0.585
60%	3.116	1.909	1.398	0.954	0.917	0.780	0.556
50%	2.859	1.726	1.307	0.892	0.834	0.722	0.502

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Table 3 - Plan Option Adjustment Factors

F. 150% of Medicare Payment Levels

Deductible per Coverage Period

0-93 Days of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.461	1.390	1.212	0.905
90%	4.075	2.519	1.938	1.365	1.328	1.149	0.871
80%	3.643	2.266	1.722	1.245	1.178	1.029	0.788
70%	3.295	2.050	1.568	1.124	1.058	0.942	0.701
60%	3.025	1.888	1.444	1.029	0.996	0.851	0.643
50%	2.759	1.730	1.320	0.938	0.905	0.793	0.585

94 Days - 6 Months of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.631	1.531	1.353	1.012
90%	4.523	2.809	2.137	1.535	1.469	1.261	0.954
80%	4.046	2.498	1.925	1.386	1.320	1.141	0.867
70%	3.656	2.278	1.739	1.261	1.199	1.050	0.784
60%	3.386	2.087	1.614	1.141	1.079	0.963	0.722
50%	3.075	1.900	1.461	1.050	0.988	0.871	0.664

Deductible per Cause

0-93 Days of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	1.257	1.191	1.012	0.739
90%	3.954	2.398	1.763	1.195	1.129	0.979	0.710
80%	3.560	2.149	1.581	1.104	1.008	0.863	0.622
70%	3.212	1.963	1.452	0.983	0.921	0.801	0.568
60%	2.946	1.801	1.328	0.921	0.859	0.743	0.535
50%	2.722	1.643	1.232	0.830	0.797	0.680	0.481

94 Days - 6 Months of Coverage

	Deductible						
Coinsurance	$ 250	$ 500	$ 1,000	$ 2,000	$ 2,500	$ 3,000	$ 5,000
100%	N/A	N/A	N/A	0.338	0.315	0.272	0.192
90%	1.051	0.635	0.474	0.322	0.299	0.257	0.184
80%	0.946	0.574	0.422	0.286	0.270	0.235	0.163
70%	0.861	0.521	0.385	0.264	0.248	0.213	0.150
60%	0.787	0.483	0.355	0.242	0.233	0.199	0.142
50%	0.722	0.437	0.331	0.226	0.212	0.184	0.128

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Table 4 - Zip Code Factors

State	Zip	Adjustment Factor
Alabama	All	0.946
Alaska	All	0.978
Arizona	All	0.649
Arkansas	All	0.631
California	900-907, 918	1.681
California	908-917, 946-947	1.230
California	All others CA	1.108
Colorado	All	0.793
Connecticut	All	0.798
Delaware	All	0.826
District of Columbia	All	0.736
Florida	330-333, 340	1.362
Florida	All other Florida	1.015
Georgia	All	0.812
Hawaii	NA	1.233
Idaho	All	0.695
Illinois	600-605, 607	0.814
Illinois	606, 608	1.057
Illinois	All others	0.802
Indiana	464	0.924
Indiana	462-463, 465-466	0.686
Indiana	all others	0.588
Iowa	All	0.764
Kansas	All	0.636
Kentucky	402	0.972
Kentucky	Other	0.853
Louisiana	All	1.039
Maine	All	1.145
Maryland	212	0.671
Maryland	All others	0.663
Massachusetts	020-022	0.905
Massachusetts	all others	0.770
Michigan	All	0.723
Minnesota	All	0.624
Mississippi	All	0.947
Missouri	All	0.647
Montana	All	0.960
Nebraska	All	0.673
Nevada	All	1.063
New Hampshire	All	0.788
New Jersey	NA	1.017
New Mexico	All	0.666
New York	100-109,111-114,116	1.083
New York	110,115,117-119	1.053
New York	all others	0.748
North Carolina	All	0.888
North Dakota	All	0.613

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Table 4 - Zip Code Factors		
State	Zip	Adjustment Factor
Ohio	All	0.650
Oklahoma	All	0.668
Oregon	All	0.699
Pennsylvania	190, 191, 194	0.963
Pennsylvania	All others	0.821
Rhode Island	All	0.951
South Carolina	All	0.762
South Dakota	All	0.534
Tennessee	All	0.635
Texas	750-753, 770-777	1.129
Texas	All other TX	0.957
Utah	All	0.623
Vermont	NA	0.593
Virginia	222, 223	0.945
Virginia	All others	0.753
Washington	All	0.664
West Virginia	250-253, 255-257	0.835
West Virginia	All others WV	0.749
Wisconsin	All	0.972
Wyoming	All	0.993

Table 5 - Trend Factor	
Frequency	Trend
Semi-Annual, beginning April 1, 2012	3.5%

SERFF Tracking Number:	*MRKC-128177674*	*State:*	*District of Columbia*
Filing Company:	*Markel Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*MSTM200-DC (11/11)*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*Short Term Medical Amendatory Endorsement*		
Project Name/Number:	*MSTM200-DC (11/11)/MSTM200-DC (11/11)*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Actuarial Justification
Comments:
Attachment:
Markel STM AM - Nat 20110923.pdf

Item Status: **Status Date:**

Satisfied - Item: Justification- Underwriting Profit
Comments:
Attachment:
Calculation of Profit Provision.pdf

Item Status: **Status Date:**

Satisfied - Item: Medicare Payment Levels
Comments:
Attachments:
2012 Sample MS-DRG Hospital Covered.pdf
2012 Sample RBRVS Surgical Covered.pdf

Item Status: **Status Date:**

Satisfied - Item: Response Cover Letter
Comments:
Attachment:
Cover Letter- Response to Objection 042712.pdf

Item Status: **Status Date:**

Satisfied - Item: Policy

SERFF Tracking Number:	*MRKC-128177674*	*State:*	*District of Columbia*
Filing Company:	*Markel Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*MSTM200-DC (11/11)*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*Short Term Medical Amendatory Endorsement*		
Project Name/Number:	*MSTM200-DC (11/11)/MSTM200-DC (11/11)*		

Comments:

Attachment:

MSTM100-DC (11-11).pdf

Item Status: **Status Date:**

Satisfied - Item: Brochure

Comments:

Attachments:

SMSTM201109_BROCHURE.pdf

Smart_STM_Brochure_Max6.pdf

Markel Insurance Company

Actuarial Memorandum

Effective November 1, 2011

For

Short Term Medical Product
Form MSTM100

Section 1: Purpose

Short Term Medical Form MSTM100 was introduced in 2007, with specific release dates varying by state. A revised Usual and Customary definition is being filed for Form MSTM100 to allow for a revised claim payment structure.

This actuarial memorandum has been prepared for the purpose of:

- Introducing new, lower cost, benefit options and demonstrating the premium rate development of these options under the existing short term medical product for Markel Insurance Company and
- Introducing experience rating methodology to be applied to business under Short Term Medical Form MSTM100.

This memorandum and the associated rates are appropriate for use with Form MSTM100 and the revised Usual and Customary definition filed in the Fall of 2011.

This memorandum assumes a pricing loss ratio of 45%. This memorandum will not be applicable to states where there is a minimum loss ratio higher than 45%.

Section 2: Product Summary

The policy provides individuals with an opportunity to obtain affordable insurance on a short term basis. Individuals have the option to select from different plans of short term medical. The same level of coverage is available for individual's dependents at additional cost.

The duration of the coverage period ranges from 30 days to 185 days.

The product is not guarantee issued or renewable. Individuals and dependents are underwritten before acceptance.

Issue ages are 2 to 64.

Premiums are payable lump sum or on a monthly basis via check payment or automated fund transfer.

The policy is marketed by licensed agents and brokers.

Benefits are payable after the Per Person Deductible at the Coinsurance Percentage up to the Lifetime maximum, subject to the benefit limits and other insurance details in specified in the policy, certificate, and schedule of benefits.

Under the new benefit options, inpatient hospital benefit claims are covered up to a multiple of the base Medicare DRG payment schedule in effect at the time of claim incurral. For physician, radiology, and pathology benefits, claims are covered up to a multiple of the Medicare RBRVS payment schedule in effect at the time of claim incurral.

Percentage of Medicare Fee Schedules	100%; 110%; 120%; 130%; 140%; 150%
Per Person Per Coverage Period Deductible option:	$250; $500; $1,000; $2,000; $2,500; $3,000; $5,000
Per Person Per Cause Deductible option:	$250; $500; $1,000; $2,000; $2,500; $3,000; $5,000
Coinsurance Percentage option:	50%, 60%, 70%, 80%, 90% or 100% up to $10,000, and 100% thereafter

Premium rates for the new benefit options are attached.

Section 3: Policy Experience

There is no experience for these new plans.

Section 4: History of Previous Rate Revisions

There are no previous rate revisions.

Section 5: Rate Development – Morbidity and Mortality Bases

Rate development for each plan consisted of determining claims costs of the medical benefits provided. To do this, we used

- Apex HRM databases
- Medicare DRG and RBRVS fee schedules and supporting information
- Original pricing assumptions for the other plans under this form
- Industry cost trend studies
- CP Risk Solutions, LLC proprietary information

The product is priced at a 45% loss ratio. Expenses and underwriting margin are as follows:

Marketing/Sales/Policy Administration	28%
Managing General Underwriter and Claims Administration	6%
Finders' Fee	1%
Premium Taxes, Overhead and Expenses	10%
Underwriting Profit	10%
Total Expenses and Profit	55%
Pricing Loss Ratio	45%

Due to the very short term nature of the product, there are no mortality or persistency assumptions reflected in the pricing.

The rate manual for the Medicare payment method reflects our estimates of claim costs for the various deductible and coinsurance plan options. We have maintained other adjustment factors and relativities, such as the age and gender slope and area factors.

An analysis of the Medicare DRG fee schedules indicates that 100% of Medicare's DRG payment schedule can be expected to result in payment of 23-26% of hospital billed charges. An analysis of the Medicare RBRVS fee schedules indicates that 100% of Medicare's RBRVS payment schedules can be expected to result in payment of 35-39% of physician billed charges (including radiology and pathology in this category). We estimate that 70-75% of billed charges fall into these categories, given the covered services on this form.

Based on this, we estimate that paying at 100% of Medicare charges for the aforementioned categories would reduce claim payments, relative to traditional payment methods by roughly 48% on average, with variations by deductible and coinsurance. Paying at 150% of Medicare charges would reduce payments by roughly 32%.

Section 6: Average Premium

Because this is a new set of plans, the mix of business is unknown. However, if the demographics and duration of coverage are similar to that of the existing business, the following are expected average premiums for a $2,500 deductible, 80% coinsurance plan, over the average duration of coverage:

100% of Medicare	$239
110% of Medicare	$253
120% of Medicare	$268
130% of Medicare	$284
140% of Medicare	$299
150% of Medicare	$315

Section 7: Variability of Results and Experience Monitoring

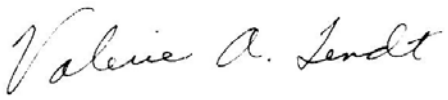
Future experience will invariably be different from projected experience and other knowledgeable individuals could have a different opinion about what the most appropriate assumptions are. Markel should monitor the experience for premium adequacy and make changes, if necessary.

Section 8: Actuarial Certification

I, Valerie A. Lendt, am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I meet the Academy's qualification standards for preparing health rate filings. I have been retained by Markel Insurance Company to prepare this memorandum. Information in this memorandum may not be appropriate for any other purposes.

I have reviewed the forms and the supporting material submitted with the filing. To the best of my knowledge and judgment, the benefits are reasonable in relation to the premium charged; and the rates are not unfairly discriminatory.

In preparing this actuarial memorandum, I relied on data Markel Insurance Company provided to me. I did not audit the information. To the extent that this data is incomplete or inaccurate, the contents of this memorandum may be materially affected.



Valerie A. Lendt, FSA, MAAA
Consultant
CP Risk Solutions, LLC
September 23, 2011

Markel Insurance Company
2010 Calculation of the Profit Provision
Accident & Health

The target rate of return of 14% is required to attract investors and has been determined by a comparison of the rates of returns of companies we consider to be our peers. The comparison is attached.

1	Target Rate of Return on Surplus		0.140
2a	Surplus as regards policyholders 2010	194,075,876	
2b	Premiums 2010	220,511,234	
3	Premium to Surplus Ratio 2b ÷ 2a		1.136
4	After Tax Ratio of Investment Income from Reserves to Surplus Line H x Line 3		0.010
5	After Tax Ratio of Investment Income from Surplus to Surplus Line E x Note H		0.039
6	After Tax Ratio of Underwriting Profit to Surplus Line 1 - (Line 4 + Line 5)		0.090
7	Pre-Tax Ratio of Underwriting Profit to Surplus Line 6 / (1 - 0.35)		0.139
8	Pre-Tax Ratio of Underwriting Profit to Premium Line 7 / Line 3		0.122
9	Selected Ratio of Underwriting Profit to Premium		0.100

Markel Insurance Company

Estimated Investment Earnings on Unearned Premium Reserves and on Loss Reserves - 2010
Preview Investment Income Method
Accident & Health

A.	Unearned Premium Reserve			
	1.	Direct Earned Premium for 2010		49,132,992
	2.	Mean Unearned Premium Reserve (1) x 34.9%		17,147,414
	3.	Deduction for Prepaid Expense		
		Commission and Brokerage Expense	18.0%	
		50% of Acquisition Expense	5.0%	
		50% of General Expense	7.4%	
		Taxes, Licenses and Fees	2.3%	
		Total		32.7%
	4.	Deduction for Federal Taxes Payable		7.0%
	5.	Subtotal (2) x [(3) + (4)]		6,798,950
	6.	Net Subject to Investment (2) - (5)		10,348,464
B.	Delayed Remission of Premium (Agent's Balances)			
	1.	Direct Earned Premium for 2010		49,132,992
	2.	Average Agents Balance		16.25%
	3.	Delayed Remission (1) x (2)		7,984,111
C.	Loss Reserve			
	1.	Direct Earned Premium for 2010		49,132,992
	2.	Expected Incurred Losses and Loss Adjustment Expenses (1) x 45.0%		22,109,846
	3.	Expected Mean Loss Reserves (2) x 0.400		8,843,939
D.	Net Subject to Investment (A.6) - (B.3) + (C.3)			11,208,292
E.	Average Rate of Return			4.42%
F.	Investment Earnings on Net Subject to Investment (D) x (E)			495,098
G.	Average Rate of Return as a Percent of Direct Earned Premium (F) ÷ (A.1)			1.01%
H.	Average Rate of Return as a Percent of Direct Earned Premium After Federal Income Taxes (G) x 89.1%			0.90%

Markel Insurance Company

Estimated Investment Earnings on Unearned Premium Reserves and on Loss Reserves - 2010
Preview Investment Income Method
Accident & Health
Explanatory Notes

Line A.1

Direct earned premiums are the earned premiums for all lines of insurance for the latest year

Line A.2

The mean unearned premium reserve is determined by multiplying the direct earned premiums in line (1) by the countrywide ratio of the direct mean unearned premium reserve to the countrywide direct earned premium as shown below.

1. Direct Earned Premium for 2010	49,132,992
2. Direct Unearned Premium reserve as of 12/31/10	16,312,006
3. Direct Unearned Premium reserve as of 12/31/09	17,992,123
4. Mean Unearned Premium Reserve [(2) + (3)] ÷ 2	17,152,065
5. Ratio (4) ÷ (1)	34.9%

Line A.3

Deductions for prepaid expense are taken because production costs and a significant portion of other company expenses in connection with the writing and handling of insurance policies, exclusive of claim adjustment expenses, are incurred when the policy is written and before the premium is paid. Therefore, the deduction for these expenses is determined by the use of the provisions selected for use in our ratemaking procedures.

Line A.4

The Tax Reform Act of 1986 taxes 20% of the unearned premium reserve. At a corporate tax rate of 35%, this tax equals 7% (0.2 x 0.35 = 0.07) of the unearned premium reserve.

Line B.2

The deduction for the delayed remission of premium is necessary because of the delay in collection and remission of premium to the company beyond the effective date of the policy. Funds for the unearned premium reserve required during the initial days of most policies must be taken from the company surplus.

Agents' balances or uncollected premiums due less than 90 days amount to 16.25% of net earned premiums as shown below.

1. Net Earned Premium for 2010	220,511,234
2. Net Agents's Balances as of 12/31/10	39,008,725
3. Net Agents's Balances as of 12/31/09	32,676,430
4. Mean Agents' Balances [(2) + (3)] ÷ 2	35,842,578
5. Ratio (4) ÷ (1)	16.25%

Markel Insurance Company

Estimated Investment Earnings on Unearned Premium Reserves and on Loss Reserves - 2010
Preview Investment Income Method
Accident & Health
Explanatory Notes

Line C-2

The expected loss and loss adjustment expense ratio reflects the expense provision used in the filing.

Line C-3

The expected mean loss reserve is determined by multiplying the expected incurred losses from line C.2 by the average countrywide ration of the mean loss and loss adjustment expenses to the incurred losses and loss adjustment expenses in the latest three available calendar years.

1. Incurred losses and LAE for 2010	31,116,910
2. Loss and LAE Reserves as of 12/31/10	16,896,592
3. Loss and LAE Reserves as of 12/31/09	9,284,903
4. Mean Loss Reserve 2010 [(2) + (3)] ÷ 2	13,090,748
5. Ratio (4) ÷ (1)	0.421
6. Estimated Reserve Discount	0.14
7. Federal Taxes Payable (ratio to reserve) (6) x 0.35	0.049
8. (5) x [1.0 - (7)]	0.400

Line E

The rate of return is the ration of net investment income earned to mean cash and investment assets for Markel Insurance Company as follows:

Year	Net Investment Income Earned	Mean Cash and Invested Assets	Rate of Return
2010	27,594,210	624,692,837	4.42%

Markel Insurance Company

Estimated Investment Earnings on Unearned Premium Reserves and on Loss Reserves - 2010
Preview Investment Income Method
Accident & Health
Explanatory Notes

Line H

The average rate of federal income tax was determined by applying current tax rates to the distribution of investment income earned 2010.

		Investment Income	Tax Rate	Income Tax
1	U.S. Government Bonds	606,260	35.0%	212,191
1.1	Bonds exempt from U.S. Tax	12,503,379	0.0%	-
1.2	Other Bonds (Unaffiliated)	6,578,853	35.0%	2,302,599
1.3	Bonds of Affiliates	-	35.0%	-
2.1	Preferred Stocks (Unaffiliated)	-	12.2%	-
2.11	Preferred Stocks of affiliates	-	0.0%	-
2.2	Common Stocks (Unaffiliated)*	2,004,191	12.2%	244,511
2.21	Common Stocks of affiliates	-	-	-
3	Mortgage Loans	-	35.0%	-
4	Real Estate	-	35.0%	-
6	Cash, cash equivalents & short-term investments	42,994	35.0%	15,048
7	Derivative Instruments	-	35.0%	-
9	Aggregate write-in for investment income	226	35.0%	79
10	Totals	21,735,903	12.76%	2,774,428
11	Deduction for Investment Expense	(1,705,789)	35.0%	(597,026)
12	Net Investment Income	20,030,114	10.87%	2,177,402

* Only 30 % of dividend income is subject to a full income tax rate of 35%. Assume 48% of the dividend income on stocks is subject to proration; that is, 15% of the remaining 70% of dividend income is taxed at a rate of 35%. The applicable tax rate is thus: 12.2% ((0.30 x 0.35) + (0.48 x 0.70 x 0.15 x 0.35) = 0.122).

Markel Insurance Company

Return on Surplus Comparison

Five Year Analysis

(Source: *Best's Key Rating Guide, Property-Casualty* , 2010 Edition)

Group	Company	Year	Total Admitted Assets	Policyholder Surplus	Return on PHS	Wt. Avg
W.R. Berkley Group	Admiral Insurance Company	2005	2,313,392	941,551	26.8%	18.0%
W.R. Berkley Group	Admiral Insurance Company	2006	2,584,972	1,109,411	27.7%	
W.R. Berkley Group	Admiral Insurance Company	2007	2,756,182	1,215,398	20.4%	
W.R. Berkley Group	Admiral Insurance Company	2008	2,514,474	1,057,364	3.8%	
W.R. Berkley Group	Admiral Insurance Company	2009	3,308,367	1,340,249	12.7%	
Argo Re Ltd	Colony Insurance Company	2005	618,056	196,646	11.3%	15.3%
Argo Re Ltd	Colony Insurance Company	2006	789,333	282,296	18.5%	
Argo Re Ltd	Colony Insurance Company	2007	878,934	315,100	20.0%	
Argo Re Ltd	Colony Insurance Company	2008	1,040,277	382,921	10.8%	
Argo Re Ltd	Colony Insurance Company	2009	1,452,875	368,347	15.5%	
Gray Insurance Group	Gray Insurance Company	2005	267,010	83,091	11.4%	8.0%
Gray Insurance Group	Gray Insurance Company	2006	315,622	96,545	16.8%	
Gray Insurance Group	Gray Insurance Company	2007	331,734	99,957	10.2%	
Gray Insurance Group	Gray Insurance Company	2008	333,678	96,960	-6.4%	
Gray Insurance Group	Gray Insurance Company	2009	343,113	113,618	8.4%	
Hartford Insurance Group	Hartford Ins. Co. of Midwest	2005	267,216	168,062	12.0%	10.4%
Hartford Insurance Group	Hartford Ins. Co. of Midwest	2006	297,359	189,930	10.8%	
Hartford Insurance Group	Hartford Ins. Co. of Midwest	2007	325,940	213,511	11.1%	
Hartford Insurance Group	Hartford Ins. Co. of Midwest	2008	355,996	240,152	9.7%	
Hartford Insurance Group	Hartford Ins. Co. of Midwest	2009	383,026	264,706	9.1%	
Assurant Insurance Group	Standard Guaranty Ins. Co.	2005	124,777	35,206	33.9%	43.1%
Assurant Insurance Group	Standard Guaranty Ins. Co.	2006	141,973	39,661	76.7%	
Assurant Insurance Group	Standard Guaranty Ins. Co.	2007	192,935	88,869	67.2%	
Assurant Insurance Group	Standard Guaranty Ins. Co.	2008	199,888	81,222	9.0%	
Assurant Insurance Group	Standard Guaranty Ins. Co.	2009	176,354	80,190	38.5%	
Travelers Group	Travelers Commercial Casualty	2005	311,877	73,449	11.3%	18.3%
Travelers Group	Travelers Commercial Casualty	2006	309,550	80,881	22.9%	
Travelers Group	Travelers Commercial Casualty	2007	320,450	87,430	20.8%	
Travelers Group	Travelers Commercial Casualty	2008	330,369	91,201	17.8%	
Travelers Group	Travelers Commercial Casualty	2009	312,129	94,846	17.9%	
Berkshire Hathaway Ins. Group	United States Liability Ins. Co.	2005	722,832	419,617	15.3%	16.3%
Berkshire Hathaway Ins. Group	United States Liability Ins. Co.	2006	832,170	479,353	22.5%	
Berkshire Hathaway Ins. Group	United States Liability Ins. Co.	2007	481,398	296,095	22.5%	
Berkshire Hathaway Ins. Group	United States Liability Ins. Co.	2008	476,888	281,505	-0.5%	
Berkshire Hathaway Ins. Group	United States Liability Ins. Co.	2009	512,550	311,435	17.2%	
Universal Insurance Group	Universal Insurance Company	2005	547,740	167,106	13.6%	15.7%
Universal Insurance Group	Universal Insurance Company	2006	535,026	183,437	16.2%	
Universal Insurance Group	Universal Insurance Company	2007	510,506	207,844	17.9%	
Universal Insurance Group	Universal Insurance Company	2008	510,535	213,592	14.4%	
Universal Insurance Group	Universal Insurance Company	2009	523,278	232,957	15.9%	
				All Company Median		**16.0%**
				Selected Target		**14.0%**

Markel Insurance Company

Short-Term Medical Form MSTM100 - Medicare Payment Plans

Exhibit A

Sample MS-DRG List with Covered Claim Amount at 100% of Medicare MS-DRG Rates for Washington, DC
Based on Medicare MS-DRG Base Rate, Wage Index, and MS-DRG Weight

MS-DRG	MS-DRG Description	Weight	DC Base	Covered Amount
39	EXTRACRANIAL PROCEDURES W/O CC/MCC	1.0305	5,405.44	5,570.31
57	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	0.9652	5,405.44	5,217.33
64	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	1.8555	5,405.44	10,029.80
74	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	0.8644	5,405.44	4,672.46
101	SEIZURES W/O MCC	0.7620	5,405.44	4,118.95
176	PULMONARY EMBOLISM W/O MCC	1.0485	5,405.44	5,667.61
189	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2694	5,405.44	6,861.67
203	BRONCHITIS & ASTHMA W/O CC/MCC	0.6133	5,405.44	3,315.16
227	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC	5.1500	5,405.44	27,838.03
238	MAJOR CARDIOVASC PROCEDURES W/O MCC	3.0979	5,405.44	16,745.52
244	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	2.0538	5,405.44	11,101.70
282	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	0.7856	5,405.44	4,246.52
291	HEART FAILURE & SHOCK W MCC	1.5010	5,405.44	8,113.57
372	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	1.2811	5,405.44	6,924.91
390	G.I. OBSTRUCTION W/O CC/MCC	0.6399	5,405.44	3,458.94
460	SPINAL FUSION EXCEPT CERVICAL W/O MCC	3.8580	5,405.44	20,854.20
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W	2.0866	5,405.44	11,279.00
482	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	1.5498	5,405.44	8,377.36
491	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	1.0067	5,405.44	5,441.66
552	MEDICAL BACK PROBLEMS W/O MCC	0.8410	5,405.44	4,545.98
638	DIABETES W CC	0.8167	5,405.44	4,414.63
684	RENAL FAILURE W/O CC/MCC	0.6409	5,405.44	3,464.35
812	RED BLOOD CELL DISORDERS W/O MCC	0.7920	5,405.44	4,281.11
853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	5.4668	5,405.44	29,550.47
917	POISONING & TOXIC EFFECTS OF DRUGS W MCC	1.4977	5,405.44	8,095.73

Washington, DC Wage Index = 1.0546

Markel Insurance Company

Short-Term Medical Form MSTM100 - Medicare Payment Plans

Exhibit B

Sample Surgical CPT Code List with Covered Claim Amount at 100% of Medicare RBRVS for Washington, DC
Based on Medicare RVUs, Conversion Factor, and Washington, DC Work, PE, and MP CPCI Factors

Surgical CPT Codes	Procedure	Non-Facility Covered Amount	Facility Covered Amount
11011	Debride skin/muscle, fx	616.14	333.96
11012	Debride skin/muscle/bone, fx	813.96	474.69
11044	Debride tissue/muscle/bone	361.25	260.94
11426	Exc h-f-nk-sp b9+marg > 4 cm	371.52	303.83
11606	Exc tr-ext mlg+marg > 4 cm	504.64	352.95
11970	Replace tissue expander	697.88	697.88
13101	Repair of wound or lesion	454.37	320.62
13121	Repair of wound or lesion	507.77	370.35
13131	Repair of wound or lesion	409.00	310.73
13132	Repair of wound or lesion	659.61	529.94
13151	Repair of wound or lesion	461.74	357.35
13152	Repair of wound or lesion	637.50	475.62
13160	Late closure of wound	905.09	905.09
14000	Skin tissue rearrangement	716.60	576.33
14001	Skin tissue rearrangement	917.10	749.10
14020	Skin tissue rearrangement	803.44	654.61
14040	Skin tissue rearrangement	876.93	728.91
14060	Skin tissue rearrangement	887.37	771.56
14061	Skin tissue rearrangement	1,161.95	953.98
15004	Wound prep, f/n/hf/g	450.68	301.03
15100	Skin splt grft, trnk/arm/leg	985.09	814.64
15120	Skn splt a-grft fac/nck/hf/g	985.49	804.03
15260	Skin full graft een & lips	1,153.66	981.99
15732	Muscle-skin graft, head/neck	1,490.30	1,296.61
15734	Muscle-skin graft, trunk	1,722.97	1,510.52
15823	Revision of upper eyelid	701.81	630.45
15830	Exc skin abd	1,317.90	1,317.90
17311	Mohs, 1 stage, h/n/hf/g	761.69	424.88
17313	Mohs, 1 stage, t/a/l	695.42	381.03
19120	Removal of breast lesion	546.52	453.96
19125	Excision, breast lesion	605.43	503.49
19301	Partical mastectomy	710.66	710.66
19302	P-mastectomy w/ln removal	982.76	982.76
19303	Mast, simple, complete	1,100.03	1,100.03
19307	Mast, mod rad	1,310.70	1,310.70
19318	Reduction of large breast	1,266.41	1,266.41
19342	Delayed breast prosthesis	1,056.97	1,056.97
19350	Breast reconstruction	959.73	772.15
19357	Breast reconstruction	1,724.20	1,724.20
19371	Removal of breast capsule	898.39	898.39
19380	Revise breast reconstruction	885.68	885.68
20680	Removal of support implant	707.02	476.63
20690	Apply bone fixation device	647.38	647.38
20694	Remove bone fixation device	484.62	380.23
20902	Removal of bone for graft	354.39	354.39
20926	Removal of tissue for graft	493.54	493.54
21555	Exc neck les sc < 3 cm	479.26	349.59
21556	Exc neck tum deep < 5 cm	591.49	591.49

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Exhibit B

Sample Surgical CPT Code List with Covered Claim Amount at 100% of Medicare RBRVS for Washington, DC
Based on Medicare RVUs, Conversion Factor, and Washington, DC Work, PE, and MP CPCI Factors

Surgical CPT Codes	Procedure	Non-Facility Covered Amount	Facility Covered Amount
21930	Exc back les sc < 3 cm	538.57	411.35
22216	Revise, extra spine segment	406.72	406.72
22524	Percut kyphoplasty, lumbar	9,062.80	603.19
22554	Neck spine fusion	1,436.55	1,436.55
22558	Lumbar spine fusion	1,722.10	1,722.10
22585	Additional spinal fusion	376.50	376.50
22600	Neck spine fusion	1,448.97	1,448.97
22610	Thorax spine fusion	1,414.76	1,414.76
22612	Lumbar spine fusion	1,788.48	1,788.48
22614	Spine fusion, extra segment	438.35	438.35
22630	Lumbar spine fusion	1,733.70	1,733.70
22632	Spine fusion, extra segment	357.84	357.84
22830	Exploration of spinal fusion	911.77	911.77
22840	Insert spine fixation device	854.09	854.09
22842	Insert spine fixation device	855.20	855.20
22845	Insert spine fixation device	825.21	825.21
22846	Insert spine fixation device	856.06	856.06
22850	Remove spine fixation device	812.71	812.71
22851	Apply spine prosth device	457.49	457.49
22852	Remove spine fixation device	777.12	777.12
22855	Remove spine fixation device	1,258.29	1,258.29
23120	Partial removal, collar bone	657.65	657.65
23410	Repair rotator cuff, acute	922.68	922.68
23412	Repair rotator cuff, chronic	958.06	958.06
23420	Repair of shoulder	1,087.34	1,087.34
23430	Repair biceps tendon	837.69	837.69
23472	Reconstruct shoulder joint	1,670.72	1,670.72
23515	Treat clavicle fracture	806.88	806.88
23600	Treat humerus fracture	367.37	341.68
23615	Treat humerus fracture	991.04	991.04
23616	Treat humerus fracture	1,395.88	1,395.88
24075	Exc arm/elbow les sc < 3 cm	564.96	370.05
24359	Repair elbow deb/attch open	737.59	737.59
24515	Treat humerus fracture	981.90	981.90
24538	Treat humerus fracture	834.13	834.13
24685	Treat ulnar fracture	734.68	734.68
25000	Incision of tendon sheath	387.47	387.47
25111	Remove wrist tendon lesion	362.63	362.63
25447	Repair wrist joint(s)	926.99	926.99
25565	Treat fracture radius & ulna	588.00	530.92
25575	Treat fracture radius/ulna	1,006.32	1,006.32
25605	Treat fracture radius/ulna	627.74	588.60
25606	Treat fx distal radial	746.43	746.43
25607	Treat fx rad extra-articul	821.97	821.97
25608	Treat fx rad intra-articul	920.16	920.16
25609	Treat fx radial 3+ frag	1,169.44	1,169.44
26055	Incise finger tendon sheath	657.79	350.74
26116	Exc hand tum deep < 1.5 cm	591.82	591.82

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Exhibit B

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Based on Medicare RVUs, Conversion Factor, and Washington, DC Work, PE, and MP CPCI Factors

Surgical CPT Codes	Procedure	Non-Facility Covered Amount	Facility Covered Amount
26160	Remove tendon sheath lesion	669.11	377.15
26410	Repair hand tendon	647.43	647.43
26418	Repair finger tendon	663.75	663.75
26608	Treat metacarpal fracture	539.12	539.12
26615	Treat metacarpal fracture	643.36	643.36
26725	Treat finger fracture, each	382.93	342.97
26727	Treat finger fracture, each	530.50	530.50
26735	Treat finger fracture, each	668.31	668.31
26951	Amputation of finger/thumb	737.01	737.01
27130	Total hip arthroplasty	1,611.36	1,611.36
27134	Revise hip joint replacement	2,145.10	2,145.10
27236	Treat thigh fracture	1,337.19	1,337.19
27244	Treat thigh fracture	1,374.85	1,374.85
27245	Treat thigh fracture	1,383.00	1,383.00
27301	Drain thigh/knee lesion	764.12	561.46
27385	Repair of thigh muscle	652.88	652.88
27446	Revision of knee joint	1,238.38	1,238.38
27447	Total knee arthroplasty	1,721.56	1,721.56
27486	Revise/replace knee joint	1,575.12	1,575.12
27487	Revise/replace knee joint	1,968.52	1,968.52
27506	Treatment of thigh fracture	1,497.19	1,497.19
27524	Treat kneecap fracture	844.29	844.29
27530	Treat knee fracture	353.60	325.87
27535	Treat knee fracture	1,007.72	1,007.72
27590	Amputate leg at thigh	919.82	919.82
27620	Explore/treat ankle joint	513.61	513.61
27650	Repair achilles tendon	750.25	750.25
27654	Repair of achilles tendon	793.71	793.71
27658	Repair of leg tendon, each	421.59	421.59
27687	Revision of calf tendon	513.65	513.65
27759	Treatment of tibia fracture	1,119.80	1,119.80
27766	Optx medial ankle fx	686.81	686.81
27786	Treatment of ankle fracture	359.40	322.70
27792	Treatment of ankle fracture	738.37	738.37
27814	Treatment of ankle fracture	869.10	869.10
27822	Treatment of ankle fracture	951.87	951.87
27823	Treatment of ankle fracture	1,076.86	1,076.86
27829	Treat lower leg joint	770.67	770.67
27840	Treat ankle dislocation	409.79	409.79
27880	Amputation of lower leg	1,039.00	1,039.00
28002	Treatment of foot infection	513.05	367.07
28003	Treatment of foot infection	792.83	628.90
28035	Decompression of tibia nerve	598.31	400.13
28080	Removal of foot lesion	589.97	408.92
28118	Removal of heel bone	669.76	461.39
28119	Removal of heel spur	595.28	403.63
28120	Part removal of ankle/heel	760.63	548.19
28122	Partial removal of foot bone	687.84	501.08

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Exhibit B

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Surgical CPT Codes	Procedure	Non-Facility Covered Amount	Facility Covered Amount
28124	Partial removal of toe	538.84	369.21
28270	Release of foot contracture	557.77	375.49
28285	Repair of hammertoe	594.57	413.93
28296	Correction of bunion	808.95	582.64
28298	Correction of bunion	810.63	561.48
28308	Incision of metatarsal	637.50	419.34
28485	Treat metatarsal fracture	592.93	592.93
28725	Fusion of foot bones	862.69	862.69
28750	Fusion of big toe joint	945.61	674.03
28805	Amputation thru metatarsal	837.88	837.88
28810	Amputation toe & metatarsal	496.96	496.96
28820	Amputation of toe	654.79	446.02
29805	Shoulder arthroscopy, dx	531.04	531.04
29807	Shoulder arthroscopy/surgery	1,160.21	1,160.21
29822	Shoulder arthroscopy/surgery	647.93	647.93
29823	Shoulder arthroscopy/surgery	707.39	707.39
29824	Shoulder arthroscopy/surgery	762.23	762.23
29826	Shoulder arthroscopy/surgery	197.09	197.09
29827	Arthroscop rotator cuff repr	1,207.66	1,207.66
29828	Arthroscopy biceps tenodesis	1,033.54	1,033.54
29848	Wrist endoscopy/surgery	575.32	575.32
29862	Hip arthroscopy/surgery	918.15	918.15
29863	Hip arthroscopy/surgery	918.13	918.13
29873	Knee arthroscopy/surgery	591.05	591.05
29874	Knee arthroscopy/surgery	604.98	604.98
29875	Knee arthroscopy/surgery	558.06	558.06
29876	Knee arthroscopy/surgery	736.76	736.76
29877	Knee arthroscopy/surgery	699.97	699.97
29879	Knee arthroscopy/surgery	744.65	744.65
29880	Knee arthroscopy/surgery	646.26	646.26
29881	Knee arthroscopy/surgery	620.13	620.13
29888	Knee arthroscopy/surgery	1,108.83	1,108.83
29893	Scope, plantar fasciotomy	690.99	476.91
29898	Ankle arthroscopy/surgery	639.42	639.42
30130	Excise inferior turbinate	445.02	445.02
30140	Resect inferior turbinate	518.29	518.29
30520	Repair of nasal septum	719.19	719.19
31254	Revision of ethmoid sinus	308.64	308.64
31255	Removal of ethmoid sinus	451.22	451.22
31267	Endoscopy, maxillary sinus	358.14	358.14
31276	Sinus endoscopy, surgical	569.08	569.08
31541	Larynscop w/tumr exc + scope	301.11	301.11
31600	Incision of windpipe	442.27	442.27
32220	Release of lung	1,804.70	1,804.70
32480	Partial removal of lung	1,679.80	1,679.80
32650	Thoracoscopy, surgical	760.18	760.18
33025	Incision of heart sac	909.80	909.80
33208	Insertion of heart pacemaker	593.72	593.72

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Exhibit B

Sample Surgical CPT Code List with Covered Claim Amount at 100% of Medicare RBRVS for Washington, DC
Based on Medicare RVUs, Conversion Factor, and Washington, DC Work, PE, and MP CPCI Factors

Surgical CPT Codes	Procedure	Non-Facility Covered Amount	Facility Covered Amount
33213	Insertion of pulse generator	397.70	397.70
33225	L ventric pacing lead add-on	511.78	511.78
33233	Removal of pacemaker system	272.67	272.67
33240	Insert pulse generator	437.98	437.98
33249	Eltrd/insert pace-defib	1,024.11	1,024.11
33405	Replacement of aortic valve	2,610.05	2,610.05
33430	Replacement of mitral valve	3,198.13	3,198.13
33510	CABG, vein, single	2,216.72	2,216.72
33518	CABG, artery-vein, two	466.30	466.30
33519	CABG, artery-vein, three	617.46	617.46
33521	CABG, artery-vein, four	742.59	742.59
33530	Coronary artery, bypass/reop	594.23	594.23
33533	CABG, arterial, single	2,146.54	2,146.54
33534	CABG, arterial, two	2,517.83	2,517.83
33863	Ascending aortic graft	3,580.61	3,580.61
33961	External circulation assist	614.46	614.46
33967	Insert ia percut device	296.72	296.72
34201	Removal of artery clot	1,194.89	1,194.89
34812	Xpose for endoprosth, femorl	386.72	386.72
35301	Rechanneling of artery	1,222.59	1,222.59
35371	Rechanneling of artery	958.10	958.10
35476	Repair venous blockage	2,094.84	348.76
35566	Artery bypass graft	1,947.54	1,947.54
35646	Artery bypass graft	2,002.86	2,002.86
35656	Artery bypass graft	1,264.36	1,264.36
36215	Place catheter in artery	1,382.04	273.31
36216	Place catheter in artery	1,535.33	310.39
36217	Place catheter in artery	2,552.54	369.34
36245	Place catheter in artery	1,327.69	276.46
36246	Place catheter in artery	1,215.93	305.38
36247	Place catheter in artery	2,067.02	363.76
36475	Endovenous rf, 1st vein	2,156.03	398.54
36478	Endovenous laser, 1st vein	1,698.74	397.14
36558	Insert tunneled cv cath	937.76	314.28
36561	Insert tunneled cv cath	1,418.48	399.47
36571	Insert picvad cath	1,551.48	362.02
36821	Av fusion direct any site	796.38	796.38
36830	Artery-vein nonautograft	756.00	756.00
37182	Insert hepatic shunt (tips)	933.28	933.28
37202	Transcatheter therapy infuse	375.47	375.47
37204	Transcatheter occlusion	998.69	998.69
37205	Transcath iv stent, percut	5,160.43	484.12
38100	Removal of spleen, total	1,259.88	1,259.88
38510	Biopsy/removal, lymph nodes	589.35	469.47
38525	Biopsy/removal, lymph nodes	481.29	481.29
38571	Laparoscopy, lymphadenectomy	875.49	875.49
38746	Remove thoracic lymph nodes	246.42	246.42
38770	Remove pelvis lymph nodes	886.53	886.53

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Short-Term Medical Form MSTM100 - Medicare Payment Plans

Exhibit B

Sample Surgical CPT Code List with Covered Claim Amount at 100% of Medicare RBRVS for Washington, DC
Based on Medicare RVUs, Conversion Factor, and Washington, DC Work, PE, and MP CPCI Factors

Surgical CPT Codes	Procedure	Non-Facility Covered Amount	Facility Covered Amount
39400	Visualization of chest	578.30	578.30
42145	Repair palate, pharynx/uvula	814.83	814.83
42415	Excise parotid gland/lesion	1,207.64	1,207.64
42440	Excise submaxillary gland	477.49	477.49
42820	Remove tonsils and adenoids	334.99	334.99
42821	Remove tonsils and adenoids	348.07	348.07
43242	Uppr gi endoscopy w/us fn bx	475.49	475.49
43244	Upper GI endoscopy/ligation	332.00	332.00
43246	Place gastrostomy tube	283.14	283.14
43255	Operative upper GI endoscopy	317.71	317.71
43259	Endoscopic ultrasound exam	341.38	341.38
43260	Endo cholangiopancreatograph	389.44	389.44
43262	Endo cholangiopancreatograph	480.36	480.36
43264	Endo cholangiopancreatograph	576.18	576.18
43268	Endo cholangiopancreatograph	487.70	487.70
43269	Endo cholangiopancreatograph	532.20	532.20
43271	Endo cholangiopancreatograph	479.96	479.96
43280	Laparoscopy, fundoplasty	1,191.11	1,191.11
43644	Lap gastric bypass/roux-en-y	1,899.82	1,899.82
43770	Lap place gastr adj device	1,230.45	1,230.45
44005	Freeing of bowel adhesion	1,199.50	1,199.50
44120	Removal of small intestine	1,338.90	1,338.90
44140	Partial removal of colon	1,472.34	1,472.34
44143	Partial removal of colon	1,829.58	1,829.58
44145	Partial removal of colon	1,821.27	1,821.27
44146	Partial removal of colon	2,327.54	2,327.54
44160	Removal of colon	1,363.18	1,363.18
44180	Lap, enterolysis	1,011.71	1,011.71
44204	Laparo partial colectomy	1,691.32	1,691.32
44205	Lap colectomy part w/ileum	1,471.65	1,471.65
44207	L colectomy/coloproctostomy	2,006.61	2,006.61
44300	Open bowel to skin	927.46	927.46
44320	Colostomy	1,322.10	1,322.10
44602	Suture, small intestine	1,535.09	1,535.09
44625	Repair bowel opening	1,121.37	1,121.37
44626	Repair bowel opening	1,759.79	1,759.79
44950	Appendectomy	705.65	705.65
44960	Appendectomy	959.15	959.15
44970	Laparoscopy, appendectomy	660.30	660.30
45380	Colonoscopy and biopsy	551.75	292.00
45382	Colonoscopy/control bleeding	721.18	371.72
45383	Lesion removal colonoscopy	661.79	376.76
45384	Lesion remove colonoscopy	545.81	304.00
45385	Lesion removal colonoscopy	619.22	346.01
46040	Incision of rectal abscess	597.89	460.07
46200	Removal of anal fissure	497.80	363.23
46255	Remove int/ext hem 1 group	570.44	391.83
46260	Remove in/ex hem groups = 2	524.02	524.02

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Exhibit B

Sample Surgical CPT Code List with Covered Claim Amount at 100% of Medicare RBRVS for Washington, DC
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Surgical CPT Codes	Procedure	Non-Facility Covered Amount	Facility Covered Amount
46280	Remove anal fist complex	519.14	519.14
46947	Hemorrhoidopexy by stapling	423.08	423.08
47100	Wedge biopsy of liver	930.19	930.19
47562	Laparoscopic cholecystectomy	825.60	825.60
47563	Laparo cholecystectomy/graph	789.67	789.67
47600	Removal of gallbladder	1,188.89	1,188.89
49000	Exploration of abdomen	848.34	848.34
49002	Reopening of abdomen	1,142.96	1,142.96
49020	Drain abdominal abscess	1,743.84	1,743.84
49320	Diag laparo separate proc	362.60	362.60
49321	Laparoscopy, biopsy	383.68	383.68
49500	Rpr ing hernia, init, reduce	453.98	453.98
49505	Prp i/hern init reduc >5 yr	573.56	573.56
49507	Prp i/hern init block >5 yr	648.37	648.37
49520	Rerepair ing hernia, reduce	695.18	695.18
49525	Repair ing hernia, sliding	631.38	631.38
49560	Rpr ventral hern init, reduc	810.11	810.11
49561	Rpr ventral hern init, block	1,019.97	1,019.97
49565	Rerepair ventrl hern, reduce	844.65	844.65
49566	Rerepair ventrl hern, block	1,031.73	1,031.73
49568	Hernia repair w/mesh	292.15	292.15
49570	Rpr epigastric hern, reduce	460.98	460.98
49585	Rpr umbil hern, reduc > 5 yr	491.06	491.06
49587	Rpr umbil hern, block > 5 yr	527.45	527.45
49650	Lap ing hernia repair init	472.75	472.75
49652	Lap vent/abd hernia repair	756.84	756.84
49653	Lap vent/abd hern proc comp	944.85	944.85
49654	Lap inc hernia repair	858.50	858.50
49905	Omental flap, intra-abdom	385.19	385.19
50081	Removal of kidney stone	1,418.47	1,418.47
50545	Laparo radical nephrectomy	1,488.71	1,488.71
50590	Fragmenting of kidney stone	932.61	630.86
50715	Release of ureter	1,313.51	1,313.51
51726	Complex cystometrogram	342.02	342.02
52234	Cystoscopy and treatment	273.22	273.22
52235	Cystoscopy and treatment	320.24	320.24
52240	Cystoscopy and treatment	558.17	558.17
52276	Cystoscopy and treatment	295.29	295.29
52351	Cystouretero & or pyeloscope	349.08	349.08
52352	Cystouretero w/stone remove	410.12	410.12
52353	Cystouretero w/lithotripsy	470.03	470.03
52601	Prostatectomy (TURP)	934.48	934.48
52648	Laser surgery of prostate	2,302.71	769.49
53852	Prostatic rf thermotx	2,439.81	694.14
54520	Removal of testis	367.65	367.65
55040	Removal of hydrocele	381.16	381.16
55845	Extensive prostate surgery	1,813.07	1,813.07
55866	Laparo radical prostatectomy	1,924.76	1,924.76

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Exhibit B

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Surgical CPT Codes	Procedure	Non-Facility Covered Amount	Facility Covered Amount
55875	Transperi needle place, pros	848.68	848.68
56620	Partial removal of vulva	572.16	572.16
57240	Repair bladder & vagina	745.29	745.29
57250	Repair rectum & vagina	754.95	754.95
57260	Repair of vagina	929.36	929.36
57267	Insert mesh/pelvic flr addon	286.34	286.34
57282	Colpopexy, extraperitoneal	565.51	565.51
57288	Repair bladder defect	797.64	797.64
57520	Conization of cervix	349.47	309.10
57530	Removal of cervix	390.45	390.45
58140	Myomectomy abdom method	1,031.55	1,031.55
58146	Myomectomy abdom complex	1,295.69	1,295.69
58150	Total hysterectomy	1,117.71	1,117.71
58180	Partial hysterectomy	1,073.52	1,073.52
58200	Extensive hysterectomy	1,473.53	1,473.53
58210	Extensive hysterectomy	1,973.87	1,973.87
58260	Vaginal hysterectomy	929.51	929.51
58262	Vag hyst including t/o	1,035.93	1,035.93
58541	Lsh, uterus 250 g or less	969.35	969.35
58542	Lsh w/t/o ut 250 g or less	1,081.87	1,081.87
58545	Laparoscopic myomectomy	1,004.11	1,004.11
58550	Laparo-asst vag hysterectomy	992.38	992.38
58552	Laparo-vag hyst incl t/o	1,101.55	1,101.55
58553	Laparo-vag hyst, complex	1,272.74	1,272.74
58558	Hysteroscopy, biopsy	433.67	299.10
58561	Hysteroscopy, remove myoma	612.58	612.58
58563	Hysteroscopy, ablation	2,053.30	384.29
58571	Tlh w/t/o 250 g or less	1,158.03	1,158.03
58605	Division of fallopian tube	372.02	372.02
58660	Laparoscopy, lysis	754.49	754.49
58661	Laparoscopy, remove adnexa	720.89	720.89
58662	Laparoscopy, excise lesions	791.54	791.54
58670	Laparoscopy, tubal cautery	412.97	412.97
58671	Laparoscopy, tubal block	412.57	412.57
58720	Removal of ovary/tube(s)	811.28	811.28
58740	Adhesiolysis tube, ovary	984.23	984.23
58925	Removal of ovarian cyst(s)	830.93	830.93
58940	Removal of ovary(s)	583.53	583.53
59151	Treat ectopic pregnancy	849.24	849.24
59400	Obstetrical care	2,356.57	2,356.57
59409	Obstetrical care	916.95	916.95
59410	Obstetrical care	1,166.91	1,166.91
59425	Antepartum care only	519.76	400.69
59426	Antepartum care only	930.58	706.71
59510	Cesarean delivery	2,612.63	2,612.63
59514	Cesarean delivery only	1,035.92	1,035.92
59515	Cesarean delivery	1,415.13	1,415.13
59610	Vbac delivery	2,474.92	2,474.92

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Exhibit B

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Surgical CPT Codes	Procedure	Non-Facility Covered Amount	Facility Covered Amount
59618	Attempted vbac delivery	2,654.68	2,654.68
59812	Treatment of miscarriage	362.79	335.87
59820	Care of miscarriage	437.09	408.55
59821	Treatment of miscarriage	439.31	408.73
60220	Partial removal of thyroid	795.89	795.89
60240	Removal of thyroid	1,025.70	1,025.70
60260	Repeat thyroid surgery	1,220.92	1,220.92
60280	Remove thyroid duct lesion	506.30	506.30
60500	Explore parathyroid glands	1,071.98	1,071.98
61107	Drill skull for implantation	352.65	352.65
61154	Pierce skull & remove clot	1,430.89	1,430.89
61312	Open skull for drainage	2,333.07	2,333.07
61313	Open skull for drainage	2,229.98	2,229.98
61510	Removal of brain lesion	2,457.25	2,457.25
61512	Remove brain lining lesion	2,864.06	2,864.06
61624	Transcath occlusion, cns	1,215.30	1,215.30
62223	Establish brain cavity shunt	1,192.21	1,192.21
63012	Removal of spinal lamina	1,340.13	1,340.13
63030	Low back disk surgery	1,091.65	1,091.65
63042	Laminotomy, single lumbar	1,461.92	1,461.92
63045	Removal of spinal lamina	1,432.59	1,432.59
63047	Removal of spinal lamina	1,241.58	1,241.58
63056	Decompress spinal cord	1,660.84	1,660.84
63075	Neck spine disk surgery	1,547.30	1,547.30
63081	Removal of vertebral body	1,986.49	1,986.49
63267	Excise intraspinal lesion	1,550.16	1,550.16
63650	Implant neuroelectrodes	474.01	474.01
64708	Revise arm/leg nerve	557.96	557.96
64718	Revise ulnar nerve at elbow	667.64	667.64
64721	Carpal tunnel surgery	485.09	481.83
65426	Removal of eye lesion	735.64	533.38
65855	Laser surgery of eye	382.81	334.70
66170	Glaucoma surgery	1,331.49	1,331.49
66711	Ciliary endoscopic ablation	690.43	690.43
66761	Revision of iris	353.59	288.76
66821	After cataract laser surgery	372.07	350.05
66982	Cataract surgery, complex	1,181.70	1,181.70
66984	Cataract surg w/iol, 1 stage	854.19	854.19
67036	Removal of inner eye fluid	1,065.10	1,065.10
67040	Laser treatment of retina	1,578.00	1,578.00
67041	Vit for macular pucker	1,466.59	1,466.59
67042	Vit for macular hole	1,674.35	1,674.35
67108	Repair detached retina	1,780.93	1,780.93
67113	Repair retinal detach, cplx	1,932.00	1,932.00
67145	Treatment of retina	588.21	553.55
67210	Treatment of retinal lesion	593.13	569.48
67228	Treatment of retinal lesion	1,173.24	1,084.34
67311	Revise eye muscle	674.83	674.83

Markel Insurance Company

Short-Term Medical Form MSTM100 - Medicare Payment Plans

Exhibit B

Sample Surgical CPT Code List with Covered Claim Amount at 100% of Medicare RBRVS for Washington, DC
Based on Medicare RVUs, Conversion Factor, and Washington, DC Work, PE, and MP CPCI Factors

Surgical CPT Codes	Procedure	Non-Facility Covered Amount	Facility Covered Amount
67312	Revise two eye muscles	813.92	813.92

Washington, DC Work GPCI Factor	1.049
Washington, DC PE GPCI Factor	1.198
Washington, DC MP GPCI Factor	1.130
2012 Conversion Factor	34.0376

MARKEL

May 4, 2012

District of Columbia Department of Insurance
Life & Health Division
810 First Street, NE, Suite 701
Washington, DC 20002

Dear Darniece Shirley,

Please see our response to your objection on 02/15/12 regarding filing MRKC-127663136.

Your questions were as follows **(answers in bold)**:

1. What is the corresponding forms' filing SERFF Tracking #? **MRKC-127663137**

2. Objections from Monica Myers dated February 15, 2012... there were 8 total objections, however only 6 were answered here. Please respond to the outstanding objections.

a. Submit your marketing materials for this product. **Please see attached brochures for both agents we currently have.**

b. List specifically what this product covers. **Hospital Charges, Ambulatory Surgical Center Charges, Skilled Nursing Facility Confinement Charges, Physician, Surgeon and Anesthesiologist Charges, Nursing Charges, Physical Medicine Charges, Home Health Agency Charges, Hospice Care and Services, Spinal Manipulation or Adjustment, Mammography/Pap Smear, Human Organ and Tissue Transplants, Bone Mass Measurement and Osteoporosis, Services and Supplies, Diabetes, Mental Illness, Substance Abuse, Preventive and Primary Care Services, and Prostate Cancer Screening.**

3. Response #2... Please note this department has jurisdiction for DC resident policyholders only.

Noted.

4. Response #5... Please confirm the Finder's Fee is paid once at acquisition of the new business.

The Finder's Fee is no longer paid.

5. Please note, the Department would prefer the minimum loss ratio to be higher than 45% and will not approve rate increases if the financial obligations of this product are not met.

Noted.

Markel
4600 Cox Road, Glen Allen, VA 23060-9817 (800) 431-1270 (804) 527-2700
www.markelinsurance.com

6. Please explain the usage of Medicare base rates, fee schedules, payment method, etc. for this new set of accident and sickness benefits. Does this product correspond to Medicare Advantage rates, etc.?

Medicare base rates are used to adjudicate claims so we can provide a more affordable option to our customers. Monthly premiums are lower using the Medicare base rates than our other product options. This product does not correspond to Medicare Advantage rates.

7. Please clarify Section 2: Product Summary... Are the covered benefits limited to inpatient hospital, physician, radiology, and pathology as shown? If not, please provide a detailed description of benefits.

The covered benefits are not limited to those indicated. I have included in the response to question 1 a list of all benefits covered. For further detail on benefits I have included a copy of the approved policy.

8. Section 6: Average Premium... It is noted that the expected average premiums are shown over the average duration of coverage. What have you determined to be the average duration of coverage? What supports this?

The average duration of coverage in DC is 2.11 months. We have determined this through previous policy experience.

9. Exhibit A... The sampling shows two factors (Weight & DC Base) to determine the Covered Amount and lastly a Washington, DC Wage Index of 1.0546. Where does the wage index calculate into the exhibit?

Labor	NonLabor	Total	
Base Rate	3,584	1,625	
Wage Index	1.0546	1	
Product	3,780.00	1,625.44	5,405.44

2012 IPPS base rate is $5209.74. If wage index >1, then 68.8% is the labor portion, otherwise 62%
NonLabor is adjusted COLA for AK and HI only

The DC wage index is used against the labor base rate to calculate the DC base that is in the exhibit provided. Then that DC base is used against each MS-DRG's weight to get the payment for each MS-DRG.

Sincerely,

Katie J Savino

Katie Savino
Regulatory Compliance Specialist

Enclosure:

MARKEL lNSURANCE COMPANY
Deerfield, IL

MASTER POLICY

SHORT TERM MEDICAL INSURANCE

Group Policy Number:	[12345]
Group Policy Date:	[Month, Day, Year]
Insuring Members of the:	[ABC Group] (called the "Organization")
Policyholder:	[ABC Policyholder]

The Group Policy will be administered on Our behalf by the "Administrator:" [ABC Administrator]

This Group Policy is delivered in District of Columbia and shall be governed by the laws thereof.

The consideration for this Group Policy is the Application of the Policyholder and the payment of premiums as provided in the Group Policy. This Group Policy, the attached Application of the Policyholder, and any individual applications of Members constitute the entire contract. Only an executive officer of Markel Insurance Company can authorize a change of the Group Policy or Benefits.

10 DAY RIGHT TO RETURN THE GROUP POLICY

If for any reason the Policyholder is not satisfied with this Group Policy, the Policyholder may return it to Markel within 10 days after the Policyholder receives it. We will refund any premium paid and the Group Policy and all Certificates issued under the Group Policy will be deemed void, just as though they had not been issued.

THIS IS A NON-RENEWABLE SHORT-TERM INSURANCE POLICY.

LIMITED BENEFIT, PLEASE READ ALL DOCUMENTS CAREFULLY.

Markel Insurance Company

[__F. Michael Crowley____]
President

[___*Linda S. Rotz*____]
Secretary

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SCHEDULE OF BENEFITS

Coverage is provided under Group Policy Number: [12345] [ABC PLAN #]

Issued to Group Policyholder: [ABC Policyholder]

Coverage Period: [30 – 185 days]
Effective Date:
Expiration Date:

The premium payable for this insurance is on file with the Administrator, Markel Insurance Company, and the Policyholder.

Premium Payment Intervals available to Insured Persons: [Monthly/Quarterly/Semi-Annually]

Premium Due Date: The Effective Date and the first day of each succeeding interval.

Hospital admissions and lengths of stay are subject to pre-certification by a Professional Review Association as stated below:

PRE-ADMISSION CERTIFICATION NOTICE:

This Policy requires a Pre-Admission Certification by a "Professional Review Organization" prior to Inpatient hospitalization or surgery of an Insured Person as follows:

(a) Ten days prior to a non-emergency hospitalization; surgical procedure; or
(b) Within 48 hours or on the first business day following an Emergency admission; or
(c) Within 48 hours of delivery for complicated childbirth.

The Professional Review Organization shall review the applicable information and determine the following:

(a) Medical necessity of the Inpatient hospitalization and/or surgical procedure to be performed;
(b) The appropriate length of stay; and
(c) Any appropriate extension(s) of the length of stay beyond that which was initially certified.

The Professional Review Organization's purpose is to determine medical necessity only. A determination of medical necessity does not guarantee or imply benefits at any time. All Inpatient hospitalizations and/or surgical procedures are subject to the Limitations and Exclusions of the Group Policy.

Non-compliance with the Pre-Admission Certification procedure will result in a reduction in benefits to the lesser of: $1,000; or 50% of the Eligible Expense. This penalty will be taken no more frequently than once per Inpatient hospitalization or surgery, unless the Insured Person is incapacitated and unable to contact Us. In such cases, a representative of the Insured Person, their legal agent, or the provider of service must contact Us as soon as possible.

Information and procedures necessary for Pre-Admission Certification have been issued to each Insured Person. An Insured Person may obtain more information regarding Pre-Certification and its procedures from the Administrator.

The Deductible Amount, Coinsurance Percentage Payable, Coinsurance Limit, and Overall Maximum Benefit Payable amount(s) are applicable to each Insured Person and for all benefits unless specifically noted elsewhere in the Group Policy.

[DEDUCTIBLE AMOUNT PER COVERAGE PERIOD:

For all Eligible Expenses, with the exception of Mammograms and Pap Smears:	[$250 - $5000] per person, per Coverage Period
Mammograms and Pap Smears:	Not subject to the Deductible, only Coinsurance Percentage Payable is applicable.**]**

[OR]

[DEDUCTIBLE AMOUNT PER CAUSE:

For all Eligible Expenses with the exception of:	
Mammograms and Pap Smears:	[$250 - $1000 per person, per cause, as elected
Mammograms and Pap Smears:	Not subject to Deductible

If you elect the Per Cause Deductible, You must satisfy Your elected Deductible Amount for each incident or subsequent incidents for the same Injury or Sickness before any other Eligible Expenses will be paid for such incident.**]**

COINSURANCE LIMIT: (Out of Pocket Limit)	$10,000 per person, per Coverage Period, subject to the Overall Maximum Benefit Payable.

COINSURANCE PERCENTAGE PAYABLE: (After satisfaction of the Deductible Amount)

For all conditions, unless specifically noted elsewhere in the Policy:	[50% - 100%] of Eligible Expenses up to the Coinsurance Limit. Thereafter, [80% - 100%]. All Eligible Expenses are subject to Usual and Customary Charges and the Overall Maximum Benefit Payable.

[MENTAL/NERVOUS DISORDERS [INCLUDING SUBSTANCE ABUSE TREATMENT]

(1) InPatient:	Same as the coinsurance percentage payable for any other condition under the Group Policy, subject to the Maximum Lifetime Benefit payable, with a minimum of 60 days per year.

(2) OutPatient:	Same as the coinsurance percentage payable for any other condition under the Group Policy, subject to the Maximum Lifetime Benefit payable, with a minimum rate of 75% for the first 40 visits per year.
(3) Detoxification Treatment:	Same as the coinsurance percentage payable for any other condition under the Group Policy, subject to the Maximum Lifetime Benefit payable, with a minimum of 12 days annually.

HOSPITAL INPATIENT DAILY ROOM RATE:

A. For normal care:	The Average Semi-Private Room Rate
B. For intensive care:	[1 - 3] times the Average Semi-Private Room Rate

SURGEON:	Professional Fees Payable
ASSISTANT SURGEON/CO-SURGEON:	Up to 20% of the lead surgeon's allowable benefit.
SURGEON'S ASSISTANT:	Up to 15% of the lead surgeon's allowable benefit.
ANESTHESIOLOGIST:	Up to 20% of the lead surgeon's allowable benefit.

PRIVATE DUTY NURSING

Maximum Rate:	$75 per 8 hour shift
Maximum Payment Period:	90 shifts per Coverage Period

SKILLED NURSING FACILITY

Maximum Daily Room Rate:	$30 per day
Maximum Payment Period:	30 days per Coverage Period

GROUND and AIR AMBULANCE SERVICES

Maximum Benefit:	$250 per trip

HUMAN ORGAN and TISSUE TRANSPLANTS

Maximum Benefit:	$125,000 per person per Coverage Period

SPINAL MANIPULATION or ADJUSTMENTS

Maximum Benefit:	$1,000 per person per Coverage Period

OUTPATIENT PHYSICAL THERAPY SERVICES

Maximum Benefit:	12 visits per person per Coverage Period

HOME HEALTHCARE VISITS and SERVICES

Maximum Benefit:	40 visits per person per Coverage Period $40 per 8 hour shift
HOSPICE CARE and SERVICES:	$5,000 per person per Coverage Period
COLORECTAL CANCER SCREENING:	$300 per person per Coverage Period
DENTAL ANESTHETIC SERVICES:	$250 per person per Coverage Period
[MENTAL/NERVOUS DISORDERS:	$5,000 per person per Coverage Period**]**
[SUBSTANCE ABUSE TREATMENT:	$1,000 per person per Coverage Period**]**
OVERALL MAXIMUM BENEFIT PAYABLE (includes all conditions, all benefits):	$1,000,000 per person per lifetime.

ELIGIBILITY AND EFFECTIVE DATES

ELIGIBILITY - WHO IS ELIGIBLE

EE-10 YOU

You will be eligible for insurance on Yourself as long as:

(1) You continue to be and qualify as a Member.
(2) You are at least 2 years of age but less than 65 years of age.
(3) You are not covered as a Dependent under the Group Policy.
(4) You are not pregnant or are an expectant father at the time of application.
(5) You are required to have a social security number.
(6) You are not a member of the armed forces.
(7) You submit a written application for insurance; provide Evidence of Insurability, if evidence is required, and meet Our Enrollment and Underwriting Requirements.
(8) You pay all required premiums when due.

EE-20 YOUR SPOUSE AND DEPENDENT CHILDREN

You will be eligible to apply for insurance for Your Spouse and Dependent Children who:

(1) Meet the definitions of Spouse and Dependent Children.
(2) Are not pregnant at the time of application.
(3) Are not members of the armed forces.
(4) For whom a written application for insurance and Evidence of Insurability, if required by Us, has been approved, and each meets Our Enrollment and Underwriting Requirements.

If You and Your Spouse are both covered as Members, only one parent will be eligible for insurance on any Dependent Children You may have.

EE-30 ENROLLMENT REQUIREMENTS

You and Your Spouse and Dependent Children who desire coverage must complete and submit an application and provide any other documents (including Evidence of Insurability) as deemed necessary by Us. You must submit the required premium with Your application form. Any misrepresentation or omission of information in Your application or any documents submitted to Us may result in rescission of all coverage for all Insured Persons.

EE-40 UNDERWRITING REQUIREMENTS

All Insured Persons are subject to Our underwriting requirements. We reserve the right to accept or decline any applicant at Our discretion. Our underwriting requirements will be as determined by Us.

EE-50 ADDITIONAL CONDITIONS

Insurance on any Insured Person will not be effective unless all Eligibility Requirements are met and You receive written acceptance from Us. Insurance on an Insured Person will not be effective unless premium is paid and accepted by Us for such insurance. You will be insured for coverage on Your dependents only if You are an eligible Insured Person. Issuance of a Group Policy or Certificate is not a waiver of any of the above conditions.

EFFECTIVE DATES

ED-10 YOU

Coverage is effective on You, and Your Spouse and Dependent Children who were included in Your initial application form, as of the Effective Date shown in Your Schedule of Benefits, provided that You meet Our Eligibility, Underwriting and Enrollment requirements. Coverage will not become effective for any applicant whose medical history changes prior to coverage approval, such that the applicant's answer would be "Yes"

to any of the medical history questions in the application. If such applicant is the Member, coverage is automatically declined for all persons included in the application.]

ED-20 ADDITIONS

You may desire to apply for coverage for a previously uncovered Spouse or Dependent Child. To do so, the following requirements must be met:

(1) You must complete and submit to Us for approval, an application form for such Spouse or Dependent Child.
(2) Such person must meet Our Eligibility, Underwriting and Enrollment Requirements.
(3) You must pay any additional premium, if approved for coverage.

ED-30 EXCEPTIONS

Newborn Dependent Children

Coverage for newborn Dependent Children will become effective at birth and remain in force only for 31 days. For coverage to continue, We must be notified of the birth of such newly born Dependent Child in writing within 31 days after the date of birth. If such notice is not received within the 31-day period, a later application will be subject to Our Underwriting Requirements. If approved, coverage for the newborn will not be effective until the first of the month following such approval by Us.

ED-40 WHEN CHANGES IN COVERAGE OCCUR:

Any change in benefits which occurs automatically under the Group Policy provisions or Schedule of Benefits will become effective on the date that the status of the Insured Person changed.

Any request for an increase or decrease in either benefits or coverage is subject to the approval of Our Administrator or Us. Should changes in coverage be requested, such changes shall not become effective until the first premium due date following the date of the Administrator's or Our written approval.

If any requested change increases benefits or coverage, the effective date of the increase will be delayed for an Insured Person who is confined for medical treatment in an institution. The delay will end and the increase shall become effective on the day following his final medical discharge from such Confinement.

TERMINATION OF INSURANCE

T-10 TERMINATION OF AN INSURED PERSON'S INSURANCE:

A Member's insurance will automatically terminate on the earliest of the following dates:

(1) The date that the Group Policy terminates.
(2) The due date of a premium payment that is not paid when due, if such payment has not been made within 31 days following such premium due date.
(3) The date that We determine fraud or material misrepresentation has been made by the Member or with the Member's knowledge in filing a claim for benefits under the Group Policy.
(4) The date that the Member enters full-time active duty in the armed forces of any country or international organization.
(5) The date the Member becomes eligible for Medicare.
(6) The earlier of: (1) the date the Member's elected Coverage Period expires; or (2) [3, 6 months] from the Effective Date of the Member's insurance, whichever occurs first.
(7) The Member ceases to be a Member of the Organization. Except, if a premium payment was accepted to continue coverage past that date, such coverage will stay in force until the end of the period the premium payment covers, subject to the other provisions for termination under this section.

T-20 TERMINATION OF AN INSURED DEPENDENT'S INSURANCE:

An insured Dependent's insurance will automatically terminate on the earliest of the following dates:

(1) The date that the Group Policy terminates.
(2) The due date of a premium payment that is not paid when due, if such premium payment has not been made within 31 days following such premium due date.
(3) The date that the Dependent's insurance under the Group Policy is discontinued.
(4) The date that We determine fraud or material misrepresentation has been made by the Member or insured Dependent or with the Member's or insured Dependent's knowledge in filing a claim for benefits under the Group Policy.
(5) The date that the Member's insurance terminates, except if termination is due to the Member's death, an insured Dependent Spouse may elect to continue coverage for insured Dependents for the duration of the Coverage Period by making written request for such coverage and by continuing payments toward the cost of that insurance. When such an election is made, the Spouse will be considered the Member under the terms of the Group Policy.
(6) The date the Member or insured Dependent becomes eligible for Medicare.
(7) The date that he ceases to be an eligible Dependent, except that, if upon attaining any limiting age, a Dependent Child is mentally or physically incapable of earning his own living and is chiefly dependent upon the Member for support and maintenance, benefits with respect to said Dependent may be continued on a premium paying basis during the continuance of such incapacity, provided that: (a) proof, in writing, of such incapacity has been given to Us within 31 days after the date on which the Dependent child attains the limiting age or (b) We shall have the right during continuance of insurance to require due proof of the continuance of the incapacity and to have the Dependent child examined by Physicians designated by Us at any time during the first two years of such continuance, and not more than once each year thereafter. The continuance of insurance as described herein, shall cease in the event: (1) of the termination of the Group Policy; or (2) of the termination of the Member's insurance; or (3) of the discontinuance of Dependent's insurance under the Group Policy.
(8) The earlier of: (1) the date the Member's elected Coverage Period has expired; or (2) [3] [6] months from the Effective Date of the Member's insurance, whichever occurs first.

T-30 **TERMINATION OF THE GROUP POLICY:**

The Group Policy will terminate on the earliest of the following dates:

(1) The date the Policyholder elects to terminate the Group Policy, provided that the Policyholder gives 30 days advance written notice to Us.
(2) The date that there are no Insured Persons under the Group Policy.

We may otherwise terminate the Group Policy on the first day of any policy month by giving written notice to the Policyholder at least 30 days in advance.

PREMIUMS

P-10 The premiums applicable with respect to individual persons insured under the Group Policy are on file with the Administrator, Us, and the Policyholder. Any references to age shall refer to the person's attained age on any premium due date. The first premium due date shall be the Group Policy Effective Date. Subsequent premiums are due as noted in the Group Policy. All premiums paid to Our Administrator or Us will be fully earned at the time of payment and no premium will be refunded unless the Insured Person elects to terminate their coverage within ten days of issuance/receipt of their Certificate.

P-20 We reserve the right to change the rates on any premium due date on or after the first Group Policy Anniversary Date. 30-days advance written notice of any such change must be given to the Policyholder.

SHORT TERM MEDICAL INSURANCE

M-10 **WHAT IS COVERED:**

If an Insured Person incurs Expenses for medical diagnosis, treatment, supplies or services, as a result of Injury or Sickness which occurs while his insurance under the Group Policy is in effect, We

will pay the Coinsurance Percentage Payable, shown in the Schedule of Benefits, of all Eligible Expenses incurred during a Coverage Period in excess of the Deductible Amount, subject to the Limitations and Exclusions of the Group Policy and the Overall Maximum Benefit Payable.

M-20 ELIGIBLE EXPENSES:

Eligible Expenses are subject to a determination of Medically Necessary, Usual and Customary Charges, and Pre-Admission Certification, provided that they are not limited or excluded under Limitations and Exclusions. Eligible Expenses include the following:

(1) **HOSPITAL CHARGES** -

a) Room and board for Confinement in a Semi-Private Room, up to the Hospital's average Semi-Private Room Rate;

b) Room and board for Confinement in an Intensive Care Unit, Cardiac Unit, or other similar licensed Inpatient unit except unless specifically noted;

c) Medical services performed and supplies used during Confinement; and

d) Outpatient services performed and supplies used with the exception of individual professional fees.

(2) **AMBULATORY SURGICAL CENTER CHARGES** – Treatment in an Ambulatory Surgical Center for medical care, but only if the charges are made for a condition that would normally require Hospital care.

(3) **SKILLED NURSING FACILITY CONFINEMENT CHARGES** – Treatment in a Skilled Nursing Facility for room and board while the Insured Person is continuously Confined as a Registered Bed--Patient. The Confinement must start within 14 days after the end of a Medically Necessary Hospital Confinement of at least three consecutive days. The Confinement must be ordered by a Physician to convalesce from the Sickness or Injury that caused the prior Hospital Confinement. If, within 14 days after the end of a Skilled Nursing Facility Confinement, the Insured Person is again Confined for the same cause as for the prior Confinement, both Confinements will be deemed to be continuous and eligible for consideration of benefits.

(4) **PHYSICIAN, SURGEON, and ANESTHESIOLOGIST CHARGES** – Treatment by a duly licensed Physician for diagnosis, treatment, and surgery.

(5) **NURSING CHARGES** – Treatment by a registered graduate Nurse (R.N.) or licensed practical Nurse (L.P.N.). The charges must be for nursing care.

(6) **PHYSICAL MEDICINE CHARGES** – Treatment for rehabilitative services, including but not limited to those for occupational, physical, rehabilitative, and speech therapies. Also included is Medically Necessary preventative physical therapy for multiple sclerosis. These services must include a prescriptive care plan from a treating or referring Physician and be performed by a duly licensed Physician, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Licensed Speech Therapist (L.S.T.), or Licensed Physical Therapist (L.P.T).

(7) **HOME HEALTH AGENCY CHARGES** – Treatment by a Home Health Agency for the following treatments, services and supplies when they are furnished to a person in accordance with a Home Health Care Plan. The Plan must be implemented within 14 days after the end of a Medically Necessary Hospital Confinement, as a Registered Bed-Patient, of at least five consecutive days:

(a) Part-time or intermittent services of a Home Health Aide;

(b) Part-time or intermittent nursing care furnished, or supervised by a registered graduate Nurse (R.N.); but only if the charge is not also claimed as an Eligible Expense under (5) above;

(c) Physical, occupational or speech therapy; but only if the charge is not also claimed as an Eligible Expense under (6) above.

(d) Laboratory services by, or on behalf of, a Home Health Agency and medical supplies and Prescription Drugs which can be lawfully dispensed only by a licensed pharmacy at a Physician's written prescription; to the same extent that benefits for these services, supplies and Prescription Drugs would have been available to the Insured Person if he were then Confined as a Registered Bed Patient in a Hospital or convalescent nursing home.

Each visit by an employee of a Home Health Care Agency will count as one visit. Each four hours of service by a Home Health Aide will count as one visit. Not included are charges for: (a) domestic or housekeeping services unrelated to patient care; (b) home food services; (c) Mental/Nervous Disorder; (d) rental or purchase of renal dialysis equipment or supplies; or (e) nursing home or Skilled Nursing Facility care. The Insured Person must be under the continuing care of a Physician during the period of his Home Health Care Plan.

(8) **HOSPICE CARE AND SERVICES** – Treatment and services provided by a licensed Hospice provider to a terminally ill Insured Person with a life expectancy of six months or less. Eligible Expenses will include, but are not limited to the following:
(a) Part-time or intermittent home nursing care by or under the direction of a licensed Nurse;
(b) Physical, respiratory, or speech therapy performed by a licensed therapist;
(c) Counseling by a licensed social worker or pastoral counselor for the Insured Person, a member of the Insured Person's immediate family, the primary care giver, and individuals with significant personal ties to the Insured Person who is terminally ill.

Hospice services must be:
(a) Under active management through an agency licensed or certified to provide hospice services and which is responsible for coordinating all such services; and
(b) Provided only when the Physician has submitted written certification to Us that the Insured Person is terminally ill with a life expectancy of six months or less. Periodic reviews of medical necessity may be necessary.

This benefit does not include the services of volunteers or persons who do not regularly charge for their services.

(9) **SPINAL MANIPULATION OR ADJUSTMENT** - Treatment by a Physician or Licensed Doctor of Chiropractic for physical manipulation involving the spine; traction; inversion therapy; hot or cold packs; electrical stimulation therapy; diathermy; therapeutic exercise; neuromuscular reeducation; gait training; thermography; biofeedback therapy; hydrocollar therapy; passive motion therapy; and office visits, consultations; x-rays, laboratory and other diagnostic studies performed in connection with spinal manipulations and spinal adjustments, or spinal therapy. Charges for massage therapy are considered only when performed by a Licensed Physical Therapist or Physician in conjunction with treatment intended to rehabilitate Injury or Sickness related to loss of limb(s), damage to peripheral nerves, spinal cord, musculoskeletal system, or other soft-tissue Injury.

(10) **MAMMOGRAPHY/PAP SMEAR** – Coverage is provided for the Expense for screening by low-dose mammography for the presence of occult breast cancer for all women age 35 and older, inclusive of the following:
(a) A baseline mammogram for women 35 to 39 years of age;
(b) An annual mammogram for women 40 years of age of older; and
(c) A mammogram at the age and intervals considered Medically Necessary by the woman's health care provider for women under 40 years of age and having a history of breast cancer or other risk factors.
(d) One routine cervical cytologic screening for women.

Such charges will be exempt from any Deductible Amount applicable under the Group Policy.

(11) **BONE MASS MEASUREMENT AND OSTEOPOROSIS** – Coverage is provided for bone mass measurement and for the diagnosis and treatment of osteoporosis.

(12) **HUMAN ORGAN AND TISSUE TRANSPLANTS** - Hospital, Physician and medical supply charges for non-Experimental human organ and/or tissue transplants or replacements.

(13) **SERVICES AND SUPPLIES**:

a) X-ray exams and microscopic and laboratory tests and analyses.
b) Anesthesia, oxygen and their administration.
c) Diagnostic imaging, radioactive isotope therapies, and other therapeutic services using x-ray or radiation
d) Blood or blood derivatives and their administration.
e) Casts, splints, trusses, braces or crutches but not their replacement or repair; surgical dressing or artificial limbs or eyes excluding repair or replacement of lost items.
f) Prescription or legend drugs which are administered during a Hospital Confinement and dispensed only by a licensed pharmacy and which a Physician prescribes in writing to treat a specific Injury or Sickness.
g) Rental of an iron lung or other mechanical equipment to treat respiratory paralysis; rental of a wheelchair or Hospital bed; or equipment to administer oxygen; not to exceed purchase price.
h) Transportation of the Insured Person needing treatment by a professional ground or air ambulance to a local Hospital, only if the condition so requires**.**

(14) **DIABETES** – Benefits are covered for the equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes if prescribed by a health care professional legally authorized to prescribe such item.

(15) **MENTAL ILLNESS** - Benefits are covered for Inpatient services provided by a Hospital, non-hospital residential facility, a Physician, a Psychologist or independent Social Worker. Before an Insured may qualify to receive benefits under this endorsement, a Physician, Psychologist or independent clinical Social Worker must: 1) certify that the individual is suffering from a Mental and Nervous Disorder; 2) certify that the treatment is Medically or Psychologically Necessary; and 3) prescribe appropriate treatment which may include referral to other treatment providers.

(16) **SUBSTANCE ABUSE** – Benefits are covered for Inpatient and Outpatient services provided by a Hospital, non-hospital residential facility, an outpatient treatment facility, a Physician, a Psychologist or independent clinical Social Worker. Before an Insured may qualify to receive benefits under this endorsement, a Physician, Psychologist or independent clinical Social Worker must: 1) certify that the individual is suffering from Drug Abuse, Alcohol Abuse or a combination of both; 2) certify that the treatment is Medically or Psychologically Necessary; and 3) prescribe appropriate treatment which may include referral to other treatment providers.

(17) **PREVENTIVE AND PRIMARY CARE SERVICES** – Benefits are covered for preventive and primary care services, including physical examinations, measurements, sensory screening, neuro-psychiatric evaluation, and developmental screening; which coverage shall include unlimited visits for children up to the age of 12 years and 3 visits per year for minor children ages 12 years up to 18 years of age. Preventive and primary care services shall also include, as recommended by the Physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemogloninopathy.

(18) **PROSTATE CANCER SCREENING** – Benefits are covered for prostate cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society for the ages, family histories, and frequencies referenced in such guidelines. Coverage will not be more restrictive

than or separate from coverage provided from any other illness, condition, or disorder for purposes of determining deductibles, coinsurance or limits.

EXPENSES INCURRED: An Eligible Expense will be considered to be incurred at the time the service or the supply to which it relates to is provided.

M-30 ALLOCATION AND APPORTIONMENT OF BENEFITS:
We reserve the right to allocate the Deductible Amount to any Eligible Expenses and to apportion the payment of benefits between the Insured Person and any Insured Dependent designated by the Insured Person. Such allocation and apportionment shall be conclusive and shall be binding upon the Insured Person and all assignees.

M-40 EXTENSION OF COVERAGE:
An extension of coverage will be provided if an Insured Person is Totally Disabled and receiving benefits for a Hospital Confinement on the date that the Group Policy terminates or his coverage under the Group Policy terminates for reasons other than nonpayment of premium, fraud or material misrepresentation.

Benefits will be payable only for Eligible Expenses incurred in connection with the same Injury or Sickness causing the Total Disability at the time of termination. Timely payment of premium is required to continue coverage.

The extension of coverage will end on the earlier of:
(1) The date the Hospital Confinement for the Total Disability ends;
(2) The end of the 90 day period following his termination date;
(3) The date premium payment is not paid when due; or
(4) The date the Overall Maximum Benefit Payable has been paid. Benefits payable during this extension of coverage are subject to a new Deductible Amount and satisfaction of the Coinsurance Limit.
(5) The earliest date permissible by law.

LIMITATIONS AND EXCLUSIONS

LE-10 LIMITATIONS: Eligible Expenses are limited by the following:

(1) Hospital Inpatient Daily Room Rate Maximum - Eligible Expenses do not include charges by a Hospital for room and board and general or floor nursing care unless they are incurred while the Insured Person is a Registered Bed-Patient. Also, they do not include any portion of such a charge in excess of the Maximum Daily Room Rate shown in the Schedule of Benefits for normal care.

(2) Hospital Inpatient Intensive Care Unit Maximum - Eligible Expenses do not include any portion of the charge made by a Hospital for care and treatment received in an Intensive Care Unit that is in excess of the Intensive Care Unit Maximum shown in the Schedule of Benefits.

(3) Private Duty Nursing Maximum - Eligible Expenses do not include charges for private duty nursing service by a registered graduate Nurse (R.N.) in excess of the Maximum Private Duty Nursing Rate and Payment Period shown in the Schedule of Benefits.

(4) Skilled Nursing Facility Maximum - Eligible Expenses do not include any portion of the charge by a Skilled Nursing Facility for room and board and general or floor nursing care in excess of the Skilled Nursing Facility Maximum Daily Room Rate shown in the Schedule of Benefits and do not include any such charges for more than the Maximum Payment Period of Skilled Nursing Facility Confinement shown in the Schedule of Benefits.

(5) Ground and Air Ambulance Services Maximum - Eligible Expenses do not include charges for ambulance transportation to a local Hospital that are in excess of the Ambulance Service Maximum shown in the Schedule of Benefits.

(6) AIDS/HIV Maximum - Eligible Expenses do not include charges in excess of the Acquired Immune Deficiency Syndrome/Human Immunodeficiency Virus Maximum shown in the Schedule of Benefits.

(7) Human Organ and Tissue Transplants Maximum - Eligible Expenses do not include charges in excess of the Human Organ and Tissue Transplant Maximum shown in the Schedule of Benefits.

(8) Spinal Manipulation or Adjustment - Eligible Expenses do not include charges in excess of the Spinal Manipulation or Adjustment Maximum shown in the Schedule of Benefits.

(9) Mental/Nervous Disorders Maximum - Eligible Expenses will be limited to the Reasonable and Customary charge incurred for the treatment of Mental Illness and identified as Clinically Significant Mental Illness, in the most recent edition of the International Classification of Disease and Statistical Manual of the American Psychiatric Association. Eligible treatment or services are subject to Peer Review procedures.

(10) Substance Abuse Disorders Maximum – Eligible Expenses will be limited to the Reasonable and Customary charge incurred for the treatment of Alcohol and Drug Abuse and identified as Clinically Significant substance abuse, in the most recent edition of the International Classification of Disease and Statistical Manual of the American Psychiatric Association. Treatment regimens, which include psychiatric, psychological and other prescribed interventions shall be Eligible Expenses. Eligible treatment or services are subject to Peer Review procedures.

(11) [Mental/Nervous Disorders Lifetime Maximum - Eligible Expenses do not include those charges incurred after Maximum Payable benefits have accrued with respect to all

Mental/Nervous disorders (whether Hospital Confined or not) suffered by an Insured Person within the Coverage Period.]

(12) Eye Examinations, Eyeglasses, Hearing Aids and Surgery – Eligible Expenses do not include charges incurred in connection with routine eye examinations, eyeglasses, determination of refractive states, correction or treatment of eye refractions, the purchase, fitting or adjustment of contact lenses or glasses, or treatment of cataracts, routine hearing exams to access need for or change in hearing aids, hearing aids or their fittings, Lasik, RK or other corrective vision surgery, hearing loss surgery; unless the charges are necessarily incurred to treat, within 90 days of its occurrence, an accidental bodily Injury sustained while the Insured Person was insured for this benefit and the treatment giving rise to the charges begins within 90 days after the date of the Accident causing the Injury.

(13) Dental Work - Eligible Expenses do not include charges incurred: (1) in connection with orthodontic or dental work, diagnosis or treatment unless the charges are necessarily incurred to treat within 90 days of its occurrence an accidental Injury to Sound, Natural Teeth sustained while the Insured Person was insured for this benefit and the treatment giving rise to the charges begins within 90 days after the Accident causing the Injury; (2) for the treatment or surgery as the result of prognathism, retrognathism, microtrognathism, or any treatment or surgery to reposition the maxilla (upper jaw) mandible (lower jaw) or both maxilla and mandible; and (3) for the treatment of temporomandibular joint dysfunction (TMJ).

(14) Dental Anesthetic Services - Eligible expenses will include those for Insured Person's in a Hospital or an Ambulatory Surgical Center if any of the following applies: (1) the Insured Person is a child age 6 or under; (2) the Insured Person has a medical condition that requires hospitalization or general anesthesia for dental care; or (3) the Insured Person is disabled.

(15) Assistant Surgeon/Co-Surgeon, Surgeon's Assistant, Anesthesiologist – Eligible Expenses do not include charges in excess of the Assistant Surgeon/Co-Surgeon, Surgeon's Assistant, Anesthesiologist Maximum shown in the Schedule of Benefits.

(16) Hospice Care and Services - Eligible Expenses do not include charges in excess of the Hospice Care and Services Maximum shown in the Schedule of Benefits.

(17) Home Health Care Visits and Services – Eligible Expenses do not include charges in excess of the Home Health Care Visits and Services Maximum shown in the Schedule of Benefits.

(18) Outpatient Physical Therapy Services - Eligible Expenses do not include charges in excess of the Outpatient Physical Therapy Services Maximum shown in the Schedule of Benefits.

LE-20 EXCLUSIONS: We will not pay benefits, and charges will not accrue toward any Deductible Amount, for Expenses incurred as a result, directly or indirectly, of any of the following:

(1) **[**Pre-Existing Conditions, as defined.

(2) Expenses that the Insured Person is not required to pay, or those charges that would not have been billed if no insurance existed.

(3) Charges for custodial maintenance; pre-marital screenings or exams; routine services for general physical examinations; physical examinations that are required by third parties; diagnostics, screenings and research; preventative or prophylactic care; and immunizations, unless specifically noted in the Group Policy.

(4) Medical Expenses that are eligible for payment under an automobile medical payment benefit, regardless of fault.

(5) Injury or Sickness resulting from war, either declared or undeclared; riot or any act incidental to war or riot; while committing or attempting to commit felony; intentionally self-inflicted Injuries; suicide or attempted suicide, while sane or insane.

(6) Injury or Sickness incurred during military service or while on active duty. Upon written notice to Us of entry into active duty, any unused premium will be returned to the Insured Person on a pro-rated basis.

(7) Substance Abuse Treatment unless specifically provided by State Mandated benefits.

(8) Charges incurred by an insured Dependent who is a newborn child not yet discharged from the Hospital, unless the charges are necessarily incurred as the result of, and to treat, premature birth, congenital Injury or Sickness, or Injury or Sickness sustained during or after birth.

(9) Charges related to elective cesarean section when no complication is present or voluntary termination of a normal Pregnancy including, but not limited to, the cost of any drug, contraceptive, supply, treatment, or procedure intended to prevent conception or childbirth.

(10) Any work-related accidental bodily Injury or Sickness.

(11) Routine charges for the care and/or treatment of a normal Pregnancy or childbirth with the exception of those Expenses related to a Complication of Pregnancy as defined in the Group Policy.

(12) Any services, supplies or treatment furnished by the Insured Person, an Insured Person's Immediate Family, or Employer.

(13) Services or supplies rendered to a transplant donor of any organ or bodily element or the acquisition cost of any organ or bodily element.

(14) Services related to or for the purpose of treating infertility or causing Pregnancy, including but not limited to, diagnostic testing; drugs; medicines; artificial insemination; in vitro fertilization; and embryo transplants; or any condition or complication caused by or resulting from such treatment.

(15) Participation in high-risk sports, activities, or occupations such as: skydiving; scuba diving; bungee jumping; hang gliding; or ultra light gliding; traveling in or on any all terrain vehicles such as, but not limited to: dirt bikes, all terrain vehicles, snowmobiles, or go-carts; racing with any motorcycle, boat or any form of aircraft; participation in any sports for pay or profit; participation in inter-collegiate sports; and any rodeo events.

(16) Charges that do not meet the definition or are not specifically identified under the Group Policy as Eligible Expenses, including amounts in excess of the Usual and Customary charges for the geographic area in which the charges are incurred.

(17) Charges determined to be for educational purposes or charges that may be provided through an educational program or facility.

(18) Voluntary inhalation or ingestion of any gas, poison or poisonous substance.

(19) Cosmetic, reconstructive or plastic surgery unless:
   a) As a result of an Injury that occurred while the Insured Person was insured under the Group Policy; or
   b) To correct the disorder of a normal bodily function if the disorder had its inception while the Insured Person was insured under the Group Policy; or
   c) Expenses are incurred for reconstructive breast surgery following a mastectomy due to illness occurring within the terms of the Group Policy.

(20) Obesity, including any treatment, advice, consultation, medication, program or surgery recommended for reducing weight whether or not such weight reduction is recommended for reasons other than, or in addition, to, obesity; or any complication resulting from the treatment or surgery for weight reduction.

(21) Care or treatment of: weak, strained or flat feet; instability or imbalance of the foot; metatarsalgia; bunions; corns; calluses; or toenails; except for charges: (i) by a Hospital during Confinement; or (ii) for the care and treatment of a metabolic or peripheral vascular disease; or (iii) for immediate repair of Injury from an Accident that occurred while the Insured Person was insured under the Group Policy.

(22) Treatment related to: gender change or modification; sterilization or elective reversal of surgical procedures; breast reduction unless Medically Necessary; breast enlargement for any reason; or the treatment or testing for sexual dysfunction or inadequacies whether such condition has a physical or organic basis or origin.

(23) Services or supplies of a common household use, including but not limited to: exercise cycles; air or water purifiers; air conditioners; allergenic mattresses; and blood pressure kits.

(24) Charges for items or services of convenience, including but not limited to: admission kits; telephone; slippers; or homemaker services; supportive service focusing on activities of daily life such as bathing; dressing; feeding; or skin and/or bladder care; administration of oral medication or eye drops, except as specifically covered in the Group Policy.

(25) Experimental or investigational service, supplies, or treatments.

(26) Travel or travel expense, even though prescribed by a Physician.

(27) Outpatient Prescription Drugs; medicines; vitamins (including prenatal vitamins); mineral or food supplements; or any over the counter medicines, whether or not ordered by a Physician.

(28) Charges for the treatment of acne or varicosities of the veins.

(29) Any Expense for the treatment of Injury or Sickness occurring while intoxicated or under the influence of alcohol, illegal drugs, hallucinogenics or narcotics unless said narcotics were prescribed by a Physician and used as recommended. "Intoxicated" and "under the influence" will have the meanings determined by the laws of the jurisdiction of the geographical region in which either the Loss or the cause occurs.

(30) Charges related to transportation, except where specifically covered in the Group Policy.

(31) Expenses incurred to treat complications resulting from any treatment or care of conditions that are not covered under the Group Policy.

(32) Expenses related to diagnosing, testing for, or treating a sleeping disorder.

(33) Testing, diagnosis or treatment for or related to learning disabilities; attention deficit disorder; hyperactivity; autism; or related conditions. **]**

HP-10 **HOSPITAL PRECERTIFICATION**

This Policy requires a Pre-Admission Certification by a "Professional Review Organization" prior to Inpatient hospitalization or surgery of an Insured Person as follows:

(a) Ten days prior to a non-emergency hospitalization; surgical procedure; or
(b) Within 48 hours or on the first business day following an Emergency admission; or
(c) Within 48 hours of delivery for complicated childbirth.

The Professional Review Organization shall review the applicable information and determine the following:

(a) Medical necessity of the Inpatient hospitalization and/or surgical procedure to be performed;
(b) The appropriate length of stay; and
(c) Any appropriate extension(s) of the length of stay beyond that which was initially certified.

The Professional Review Organization's purpose is to determine medical necessity only. A determination of medical necessity does not guarantee or imply benefits at any time. All Inpatient hospitalizations and/or surgical procedures are subject to the Limitations and Exclusions of the Group Policy.

Non-compliance with the Pre-Admission Certification procedure will result in a reduction in benefits to the lesser of: $1,000; or 50% of the Eligible Expense. This penalty will be taken no more frequently than once per Inpatient hospitalization or surgery, unless the Insured Person is incapacitated and unable to contact Us. In such cases, a representative of the Insured Person, their legal agent, or the provider of service must contact Us as soon as possible.

Information and procedures necessary for Pre-Admission Certification have been issued to each Insured Person. An Insured Person may obtain more information regarding Pre-Certification and its procedures from the Administrator.

REDUCTION OF BENEFITS

To the extent that the otherwise Eligible Expense for the Hospital admission and/or length of stay and/or extensions of stay are not certified by the Professional Review Organization, We will only pay 50% of the benefits under the Group Policy which would otherwise have been payable for Eligible Expenses, unless the Insured Person is incapacitated and unable to contact Us. In such cases, the Insured Person must contact Us as soon as possible. No benefits will be payable under the Group Policy in the event such Hospital admission, length of stay or extension of stay is not Medically Necessary.

CB-10 COORDINATION OF BENEFITS

I. Applicability

A. This Coordination of Benefits ("COB") provision applies to This Plan when an Insured Person has health care coverage under more than one Plan. "Plan and This Plan" are defined below.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

(1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

(2) May be reduced when, under the order of benefits determination rules, another Plan determines its benefits first. The above reduction is described in Section IV "Effect on the Benefits of This Plan."

II. Definitions

A. "Plan" is any of these which provide benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act (42 U.S.C.A. 301, et seq.), as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

B. "This Plan" is the part of the group contract that provides benefits for health care Expenses.

C. "Primary Plan/Secondary Plan:" The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

D. "Allowable Expense" means a necessary, reasonable and customary item of Expense for health care; when the item of Expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

The difference between the cost of a private Hospital room and the cost of a Semi-Private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

III. Order of Benefit Determination Rules

A. General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

(1) The other Plan has rules coordinating its benefits with those of This Plan; and

(2) Both those rules and This Plan's rules, in Subsection B below, require that This Plan's benefits be determined before those of the other Plan.

B. Rules. This Plan determines its order of benefits using the first of the following rules which applies:

(1) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, Member or subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent; except that: if the person is also a Medicare beneficiary, Medicare is

(a) Secondary to the Plan covering the person as a Dependent; and

(b) Primary to the Plan covering the person as other than a Dependent, for example a retired employee.

(2) Dependent Child/Parents not Separated or Divorced. Except as stated in subsection (B)(3) below, when This Plan and another Pan cover the same child as a Dependent of different person, called "parents":

(a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

(b) If both parents have the same birthday, the benefits of the Plan which covered the parents longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in subsection (2)(a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

(3) Dependent Child/Separated or Divorced. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the Plan of the parent with custody of the child;

(b) Then, the Plan of the spouse of the parent with the custody of the child; and

(c) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care Expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Dependent Child/Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care Expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph III subsection B(2) above.

(5) Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule (4) is ignored.

(6) Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

(a) First, the benefits of a Plan covering the person as an employee, Member or subscriber (or as that person's Dependent);

(b) Second, the benefits under the continuation coverage.

If the other Plan does not contain the order of benefits determination described within this subsection, and if, as a result, the Plans do not agree on the order of benefits, this requirement shall be ignored.

(7) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, Member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

IV. Effect on the Benefits of this Plan

A. When This Section Applies. This Section IV applies when, in accordance with Section III "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other plans" in (B) immediately below.

B. Reduction in this Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

V. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts it needs to pay the claim.

VI. Facility of Payment

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

VII. Right of Recovery

If the amount of the payments made by Us is more than it should have paid under this COB provision, it may recover the excess from one or more of:

A. The persons it has paid or for whom it has paid;

B. Insurance companies; or

C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

CLAIM PROVISIONS AND GENERAL PROVISIONS

GP-10 CLAIM PROVISIONS:

Notice of Claim: When a claim arises, the claimant should notify Us or the Administrator of the Loss in writing. We will furnish a claim form or accept a proof of payment for covered services. This written notice of claim must be given within 30 days after commencement of any Loss covered by the Group Policy, or as soon as reasonably possible.

Proof of Loss: Written proof of Loss must be furnished to Us or to the Administrator. It must be furnished within 90 days of the Loss. Where the Group Policy provides for payments contingent upon a period of Confinement, these 90 days shall begin at the end of the period for which We are liable. If the claimant does not furnish proof within 90 days as required, benefits shall still be paid for that Loss if: (1) it was not reasonably possible to give proof within those 90 days; and (2) proof is furnished as soon as reasonably possible and, except in the absence of legal capacity, no later than one year after the end of those 90 days.

When Benefits Are Paid: We or the Administrator will make payment promptly upon receipt of due written Proof of Loss. Payment shall be made directly to the Insured Person or the provider of the service, as directed by the Insured Person in writing at the time of submitting Proof of Loss. If the Insured Person is deceased or, in Our opinion, is incapable of giving a valid receipt for payment, and if no claim has been made by a duly appointed legal representative, We shall have the option of making payment to either: (1) the Hospital or the person who actually

incurred the Loss for which payment is due; or (2) a surviving relative of the Insured Person. Such a payment shall discharge Us from all further liability to the extent of the payment made.

Appeal of Claim Denial: If a claim is denied, the Insured Person will receive written notice giving the reason for the denial. If the Insured Person wishes to appeal the denial of the claim, such appeal must be submitted in writing within 60 days from the date of notice. The Insured Person must clearly state the reasons he believes the claim decision is incorrect.

GP-20 GENERAL PROVISIONS:

Assignment and Claims of Creditors: Except as provided below, benefits under the Group Policy are not assignable unless as otherwise provided by law, benefits payments will be exempt from legal process for debts or liabilities of an Insured Person. You may direct Us to pay benefits to the person or institution on whose charges the claim is based. Any such payment that We make will fully discharge Us to the extent of the payment.

Calculation and Adjustment of Premiums: We determine the premium for each Insured Person. We have the right to change premium rates on any premium due date by giving [60 days] advance written notice to You of such change. The premium rates may also be changed at any time the terms of the Group Policy are changed.

Certificates: The Certificate describes the main features of the Group Policy. In the event of any conflict, the terms of the Group Policy will govern. Individual Certificates will be issued to each Insured Person or to the Policyholder for delivery to each Insured Person. The rights described in the Certificate are controlled by the provisions of the Group Policy and are subject to any changes in the Group Policy. The Policyholder must have the Group Policy available for inspection by Insured Persons at all reasonable times.

Changes in Benefits: Changes in the benefits of an Insured Person will apply only to Eligible Expenses or Losses incurred after the Effective Date of the change.

Clerical Error: Clerical errors made by Us in Your Schedule of Benefits, the issuance of a Certificate, or in record keeping for the Group Policy will not afford You benefits or validate insurance for which You have not applied and paid the appropriate premium and been approved by Us. We have the right to offset or recover any overpayment of benefits made under the Group Policy from You.

Conformity With Statutes: Any provision of the Group Policy that is in conflict with the statutes of the jurisdiction in which the Policyholder is located on such date is hereby amended to conform to the minimum requirements of such statutes.

Contract Changes : The effective time for any changes made shall be 12:01 A.M. Standard Time at the address of the Policyholder.

Amendment: The Group Policy may be amended or changed at any time or times by written notification to the Policyholder and Us. Insurance provided by the Group Policy may be amended, changed or canceled without the consent of any Insured Person and without prior notice to him.

Entire Contract: The entire contract consists of the Group Policy, the Certificate, the application of the association, Your application form and any other amendments, endorsements, or documents requested and accepted by Us. No change in the Group Policy or Your Certificate is valid unless approved by Our executive officer. Such approval must be signed by the officer and attached to the Group Policy and Certificate. No broker, agent or producer can change or waive any provision of the entire contract or any of Our requirements.

Grace Period: You have a 31 day grace period for the payment of each premium due after the first premium. Your coverage will continue in force during the grace period unless You have given Us prior written notice of termination. If the premium is not paid by the end of the grace period, all such insurance will end as of the due date of such premiums, and no Expenses incurred during the grace period will be considered for benefits.

Incontestability: All statements made by You will, in the absence of fraud, be deemed representations and not warranties. No such statement will be used in defense of any claim or in a contest under the Group Policy unless a written copy has been given to You. Any misstatement or omission of information made on Your application form or on any other materials on which We relied to issue, change or increase coverage will be considered a misrepresentation and may be the basis of later rescission of coverage. After coverage for an Insured Person has been in force for two years during the Insured Person's lifetime, We do not have the right to contest that coverage, except for fraud or non-payment of premiums.

Legal Proceedings: No proceedings to obtain benefits under the Group Policy may be brought against Us until the expiration of 60 days after proper written Proof of Loss and any other documentation necessary to establish what benefits are due under the provisions of the Group Policy have been received by Us. No proceedings may be brought more than three years after proof is required to be filed.

Payment of Premiums: All premiums are paid to Us, or if We direct, to Our authorized representative. Premiums are due monthly, in advance, on the first day of each policy month, or if other than monthly, the first of the month of the payment period elected by You. Each monthly premium will pay for the insurance then in effect for a period of one month for Insured Persons. Each payment for a period greater than a month will pay for the entire period selected by You. Except as otherwise provided in the Group Policy, all coverage will terminate on the premium due date if premiums are not paid when due.

Physical Exam and Autopsy: We may require, at Our own expense, medical examinations of any person for whom a claim is made or make a request for an autopsy if not prohibited by law.

Pronouns – Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine also, unless the context clearly indicates to the contrary.

Rescission: A misrepresentation or omission in the application form or other documents provided to Us might be the basis for later rescission of all coverage of all persons insured under the Certificate. Rescission voids all coverage as of the Effective Date and means that no benefits will be paid to any person for any claim submitted, whether or not such claim relates to the condition about which information was misrepresented or omitted. We will refund to You premiums paid after deduction for any claims paid out under the Group Policy by Us.

Subrogation: Upon payment of benefits for an Injury or Sickness, We will be subrogated to all rights of recovery an Insured Person may have against any third party responsible for such Sickness or Injury. This includes but is not limited to recoveries against such third party, against any liability coverage for such third party or against an Insured Person's automobile insurance in the event a claim is made under the uninsured or underinsured motorist coverage. Such right extends to all proceeds of any settlement or judgment; but is limited to the amount of benefits We have paid. You must: (1) do nothing to prejudice any right of recovery; (2) execute and deliver any required instruments or papers; and (3) do whatever else is necessary to secure such rights.

If We are precluded by law from exercising Our Subrogation Right, We may exercise Our Right of Reimbursement as defined by the Group Policy.

Right of Reimbursement

If an Insured Person incurs Expenses for Sickness or Injury that occurred due to the negligence of a third party:

(a) We have the right to reimbursement for all benefits We paid from any and all damages collected from the third party for those same Expenses whether by action at law, settlement, or compromise, by the Insured Person, the Insured Person's parents (if the Insured Person is a minor), or Insured Person's legal representative as a result of the Sickness or Injury; and

(b) We are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits we paid for that Sickness or Injury.

We shall have the right to first reimbursement out of all funds the Insured Person, the Insured Person's parents (if the Insured Person is a minor), or the Insured Person's legal representative, is or was able to obtain for the same Expenses We have paid as a result of that Sickness or Injury.

You are required to furnish any information or assistance or provide any documents that We may reasonably require in order to obtain Our rights under this provision. This provision applies whether or not the third party admits liability.

Workers' Compensation: The Group Policy is not a substitute for Workers' Compensation insurance and does not affect any requirement for Workers' Compensation coverage.

D-10 DEFINITIONS

Accident: means a sudden, unexpected and unintended event, which is identifiable and caused solely by an external physical force resulting in Injury to an Insured Person. Accident does not include a Loss due to disease or Sickness.

Administrator: means [ABC Administrator].

Alcohol Abuse – means any pattern of pathological use of alcohol that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical tolerance of by physical symptoms when it is withdrawn.

Ambulatory Surgical Center: means a licensed health care facility whose main purpose is the diagnosis or treatment of patients by surgery. It must: (1) admit and discharge the patient within the same working day; (2) be supervised by a Physician; (3) require a licensed anesthesiologist or licensed certified registered nurse anesthetist to administer anesthesia and remain during the surgery; (4) provide a post-anesthesia recovery room; and (5) have a written agreement with at least one Hospital for immediate acceptance of patients who develop complications.

It does not include: (1) a facility whose main purpose is performing terminations of Pregnancy; (2) an office maintained by a Physician for the practice of medicine; or (3) an office maintained for the practice of dentistry.

Calendar Year: means the period of time starting January 1 of a year; it ends on December 31 of the same year.

Clinically Significant – means sufficient to impair substantially a person's judgment, behavior, capacity to recognize, or ability to cope with the ordinary demands of life.

Coinsurance Limit (Out of Pocket Limit): The amount of money that You are required to pay from Your own funds for Eligible Expenses not paid by Us, such as Deductibles and Coinsurance; this does not include Expenses which are not payable by this policy.

Coinsurance Percentage Payable: means the applicable percentage specified in the Schedule of Benefits, which We will use in computing the amount payable when benefits are payable under the Group Policy after satisfaction of any Deductible Amounts.

Complications Of Pregnancy: means: (1) conditions requiring Hospital Confinement (when Pregnancy is not terminated) whose diagnoses are distinct from Pregnancy but are adversely affected by Pregnancy or are caused by Pregnancy, such as but not limited to: acute nephritis, nephrosis, cardiac decomposition, missed abortion and similar medical and surgical conditions of comparable severity; and (2) non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of Pregnancy which occurs during a period of gestation in which a

viable birth is not possible. It does not include false labor, occasional spotting, Physician prescribed rest during the period of Pregnancy, morning sickness, hyperemesis gravidarum, elective cesarean section, pre-eclampsia and similar conditions associated with the management of a difficult Pregnancy not constituting a nosologically distinct complication of pregnancy.

Confined/Confinement: means being a Registered Bed patient as an Inpatient in a facility, on the order of a Physician, for Medically Necessary medical treatment for a period of no less than 18 consecutive hours.

Coverage Period: means the maximum length of time coverage is in force.

Deductible Amount: means that amount specified in the Schedule of Benefits which is the initial out-of-pocket Expense paid by each Insured Person. Such Deductible Amount must first be satisfied by the application of Eligible Expenses which are subject to such Deductible Amount and which are incurred before any other Eligible Expenses will be payable under the Group Policy.

Dependent: means a Spouse or Dependent Child.

Dependent Child(ren): means Your unmarried Children, if any, who are primarily dependent upon You for support and maintenance. Each Child must be: (1) less than [19 – 30 years] of age; or (2) at least 19 years of age but less than [25 – 30 years] and be enrolled and attending as a full-time student at an accredited college, university, vocational or technical school. If, at the attainment of the limiting age, the Insured Person continues to support the Dependent child because of mental retardation or a physical handicap, coverage may be continued. We must receive written notice and proof of such conditions within 31 days of the child's attainment of the limiting age. Thereafter, We may require such proof once each year. "Children" means natural Children; stepchildren who are residing with You; legally adopted Children; and Children subject to Your legal guardianship.

Drug Abuse – means any pattern of pathological use of a drug that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

Effective Date: means the date coverage under the Group Policy, or an insurance or benefit provision as the case may be, goes into force for an Insured Person. It is shown in the Schedule of Benefits.

Eligible Expenses: means: (1) treatments, services and supplies which a Physician recommends as Medically Necessary to treat a covered Injury or Sickness; and (2) charges which are Usual and Customary and are incurred by the Insured Person while he is insured under the Group Policy; and (3) charges which the Insured Person is legally required to pay.

Emergency: means the sudden onset or sudden worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Evidence Of Insurability: means proof that a person is acceptable for insurance according to Our current underwriting rules. Such proof is at his expense unless otherwise stated.

Expense: means the Usual and Customary charges for Medically Necessary treatment, services and supplies. Such Expense shall not include any amount not customarily charged to persons without insurance.

Experimental: means those practices, treatments, drugs, and or therapies not accepted and approved by the American Medical Association, Federal Drug Administration and Health Care Financing Administration; not consistent with currently accepted medical practice; not legally obtainable; or not proven safe and effective.

Group Policy: means the contract issued to the Policyholder providing the benefits described herein.

Home Health Agency: means a public agency or private organization, or a sub-division of such an agency or organization, which: (1) is primarily engaged in providing skilled nursing services and other therapeutic services; (2) has policies established by a group of professional personnel (associated with the agency or organization), including one or more Physicians and one or more registered professional Nurses, to govern the services which it provides, and provides for supervision of such services by a Physician or registered professional Nurse; (3) maintains clinical records on all patients; (4) in the case of an agency or organization in any State, in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (a) is licensed pursuant to such law, or (b) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing; and (5) meets such other conditions of participation as are established under the Medicare program in the interest of the health and safety of individuals who are furnished services by such agency or organization.

Home Health Aide: means a person who: (1) provides care of a medical or therapeutic nature; and (2) reports to and is directly supervised by a Home Health Care Agency.

Home Health Care Plan: means one that meets these standards: (1) a Physician must establish and approve the plan in writing; and (2) the plan must cover a condition that would otherwise require Confinement in a Hospital or convalescent nursing home.

Home Health Care Visit: means each visit by a member of a home health care team, other than a Home Health Aide, counts as one Home Health Care Visit. Four hours of service by a Home Health Aide counts as one Home Health Care Visit.

Hospice: means care for an Insured Person who has a terminal illness resulting in a life expectancy of six months or less; the care must be recommended by the attending Physician.

Hospital: means a licensed institution which is legally constituted and operated in accordance with the laws pertaining to hospitals in the jurisdiction where it is located, and which meets all of the following requirements: (1) it is engaged primarily in providing medical care and treatment to sick and injured persons on an Inpatient basis at the patient's expense; (2) it provides 24-hour-a-day nursing service by registered, graduate Nurses; (3) it is under the supervision of a staff of duly licensed Physicians; (4) it provides organized facilities for diagnosis and for major operative surgery either on its premises or in facilities available on a prearranged basis; and (5) it is not primarily a clinic, nursing home, rest or convalescent home, extended care facility, Hospice or similar establishment nor, other than incidentally, a place for persons with mental or nervous disorders, the aged, alcoholics or drug addicts. Confinement in a special unit of a Hospital used primarily as a nursing, rest, or convalescent home shall be deemed, for the purposes of the Group Policy, to be Confinement in an institution other than a hospital.

Immediate Family: means: (1) the parent, spouse, brother, sister or children of the Insured Person; (2) a resident in the Insured Person’s household, or the Insured Person’s employer; or (3) any person related to the Insured Person by blood, marriage or legal adoption.

Injury: means bodily harm resulting from an Accident and is independent of all other causes.

Inpatient: means Confinement in a Hospital as a Registered Bed-Patient for a minimum of 18 consecutive hours for which room and board charges are made.

Insured Person: means a Member and his eligible Spouse and Dependents who meet the Eligibility Requirements and have paid the required premium.

Intensive Care Unit: means a section, ward or wing within a Hospital which is separated from other Hospital facilities and: (1) is operated exclusively for the purpose of providing professional care and treatment for critically ill patients; (2) has special supplies and equipment necessary for such care and treatment which are available on a

standby basis for immediate use; (3) provides room and board, and constant observation by registered graduate professional Nurses or other specially trained Hospital personnel; and (4) is not maintained for the purpose of providing normal postoperative recovery treatment or service.

Loss: means medical Expense sustained by an Insured Person that is covered by this Group Policy.

Medically Necessary: means a Confinement, service or supply that We determine meets each of these requirements: (1) it is ordered by a Physician for the diagnosis or the treatment of a Sickness or Injury deemed eligible within the language of this Group Policy; (2) for services or supplies, and the prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that omission would adversely affect the Insured Person's medical condition; (3) for Hospital Confinement, and the prevailing opinion within the appropriate specialty of the United States medical profession is that Inpatient acute care Confinement is necessary and any lesser level of care would adversely affect the Insured Person's medical condition; and (4) it is furnished by a provider with appropriate training, experience, staff and facilities to furnish that particular service or supply.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy.

Medically or Psychologically Necessary – means essential for the treatment of drug abuse, alcohol abuse, or mental illness, as determined by a Physician, Psychologist or Social Worker.

Member: means the person shown in the Schedule of Benefits as the primary insured who is in good standing with the Policyholder.

Mental/Nervous Disorder: means any psychiatric disease identified in the most recent edition of the International Classification of Diseases or of the American Psychiatric Association Diagnostic and Statistical Manual.

Nurse: means a licensed registered graduate professional nurse (R.N.) or a licensed practical nurse (L.P.N.) who is under the direction of a Physician. The term nurse does not include the Insured Person, the Insured Person's Immediate Family, or the Insured Person's Employer.

Outpatient: means services rendered or charges incurred by a patient at a healthcare facility, including but not limited to, a Hospital, clinic, or Ambulatory Surgical Facility without a stay or admission of 18 consecutive hours or more.

Overall Maximum Benefit Payable: means the maximum aggregate amount of benefits payable under the Group Policy for an Insured Person for Eligible Expenses. It is shown in the Schedule of Benefits.

Peer Review – means a system based on written procedures and formally established within the professions of medicine or any of its specialties, psychology, or social work in which a committee of licensed practitioners of the profession reviews another practitioner's diagnosis and treatment in a specific case and reaches conclusions and recommendations concerning the accuracy of the diagnosis, and the necessity, appropriateness, and effectiveness of the treatment provided and proposed by the practitioner compared to alternative treatments.

Psychologist – means a person licensed to practice psychology by the District pursuant to the District of Columbia Health Occupations Revision Act of 1985 or by the state or territory where the person practices medicine.

Physical Medicine: means treatment of a disease by physical agents such as: heat, cold, light, electricity, manipulation or the use of mechanical devices.

Physician: means a licensed practitioner of the healing arts who is practicing and treating within the scope and limitations of that license. The term Physician will not include the Insured Person, the Insured Person's Immediate Family, or the Insured Person's employer.

Policyholder: means the Organization in which You are a Member.

Pre-Existing Conditions: means any condition or complication thereof, that required medical treatment, advice, consultation, or Expense during the 24 months immediately before the Insured Person's Effective Date of insurance; or which produces symptoms within the 12 months immediately prior to the Insured
Person's Effective Date of insurance. These symptoms must be significant enough to establish manifestation or onset by one of the following tests: (1) they would allow a Physician to make diagnosis of the disorder; or (2) they would cause a reasonable person to seek diagnosis or treatment.

Pregnancy: means normal pregnancy, normal childbirth or elective cesarean section.

Prescription Drugs: means: (1) a legend drug; (2) injectable insulin prescribed by a Physician; (3) a compounded drug of which at least one part is a legend drug; or (4) any other drug that, under state law, may only be dispensed upon the written prescription of a Physician. It does not include an oral contraceptive for prevention of Pregnancy.

Professional Review Organization: means or refers to an organization selected by Us that provides a program of medical review services under Physicians, Nurses and record technicians.

Registered Bed-Patient: means an individual who, while Confined to a Hospital, is assigned to a bed in any department of the Hospital, and for whom a charge for room and board is made by the Hospital.

Semi-Private Room: means a room with at least two beds in a Hospital.

Semi-Private Room Rate: means: (1) the facility's most common daily charge for room and board for a Semi-Private Room; or (2) if the facility does not have Semi-Private Rooms, 80% of its daily charge for room and board for its lowest rate private room.

Sickness: means an illness, disease or infection, except Pregnancy. It includes Complications of Pregnancy only: (1) during Confinement in a Hospital; and (2) if conception occurred after the Insured Person's Effective Date. Complications of Pregnancy will be automatically included if birth occurs at least 270 days after the person's Effective Date. With respect to Dependent Children who automatically become insured under the Group Policy at birth, the term "Sickness" shall also include medically diagnosed congenital defects and birth abnormalities.

Skilled Nursing Facility: means an institution, or distinct part of an institution, which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for persons convalescing from Injury or Sickness and: (1) is approved by and is a participating Skilled Nursing Facility of Medicare; (2) has organized facilities for medical treatment and provides 24-hour-a-day nursing service under the full-time supervision of a licensed Physician or of a registered graduate professional Nurse; (3) maintains daily clinical records on each patient and has available the services of a licensed Physician under an established agreement; (4) provides appropriate methods for dispensing and administering drugs and medicines; (5) has transfer arrangements with one or more Hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one licensed Physician; and (6) is not, other than incidentally, a rest home for the aged, or a place for the treatment of mental disease, drug addiction or alcoholism.

Social Worker – means a person licensed as an independent clinical social worker by the District or who is licensed to practice social work with authority to engage in the Independent practice of psychotherapy by the state or territory where the person practices social work.

Sound Natural Tooth: means a tooth that is natural, whole, vital and free of disease.

Spinal Manipulation Or Adjustment: means the treatment of: (1) of any bodily ailment, complaint, pain or Injury, including rehabilitation or treatment related to loss of bodily part, peripheral nerves, spinal cord or musculoskeletal or

other soft tissue Sickness or Injury; and (2) by various physical, manual or mechanical means, including the use of heat, cold, light, sound, water, exercise, massage, manipulation, electric current or any other Physical Medicine service or procedure.

Spouse: means Your lawful spouse, who is not legally separated from You, and is under age 65 at the time of application. It does not include a common law spouse.

Total Disability Or Totally Disabled: means the Insured Person is prevented by reason of Injury or Sickness from engaging in his own occupation for wage or profit and any occupation to which he is suited by talent or education. A Dependent is considered to be totally disabled when he is prevented by reason of Injury or Sickness from engaging in all normal activities of a person of like age and sex in good health.

Usual And Customary: means a charge which is: (1) made by a Physician or supplier of services, medicines, or supplies; and (2) the customary charges made by others rendering or furnishing such services, medicines or supplies within an area in which the charge is incurred for Sickness or Injury comparable in severity and nature to the Injury or Sickness being treated. The term "area" as it would apply to any particular service, medicine or supply, means a county or such greater area as is necessary to obtain a representative cross section of level of charges[.] [;] [and/or] [[(3)] physician payment schedule based on Medicare's payment rates based on resource-based relative values scale (RBRVS);] [and/or] [[(4)] in-patient payment schedule based on Medicare's base payment rates for Diagnosis Related Group (DRG);] [and/or] [[(5)] a similar physician or hospital payment schedule.]

We, Us, or Our: means Markel Insurance Company.

You, Your, or Yourself: means the Insured Person.

MED SENSE GUARANTEED ASSOCIATION

Sensible Med STM

Short Term Medical Insurance

Is offered through membership with the Med Sense Guaranteed Association and is ideal for those who are:*

- Between jobs or laid off
- Waiting for employer benefits
- Part-time or temporary employees
- Recently graduated
- Without adequate health insurance

Exclusive Features Include:

- Up to $1,000,000 lifetime maximum per covered person
- Choice of coverage periods of up to 6 months
- Choice of deductible - $250, $1,000, $2,000, $3,000 or $5,000
- Coinsurance options of 50% or 80% up to $10,000
- Freedom to choose any doctor or hospital
- Choose to pay premiums two convenient ways, in a single up front payment from 30 to 180 days, or pay by convenient monthly installments

*Med Sense Guaranteed Association membership is not required in the states of: CO, KS, MN, NH, SD, UT and WA.

Insured Benefits Underwritten by:

Markel Insurance Company
Rated “A” (Excellent) by A.M. Best

Association Benefits provided by:

MSGA
Med-Sense Guaranteed Association

Distributed by:

Health Insurance Innovations
Partnered with Elite Re

This brochure provides a brief description of the plan. You must be 18 years old to apply. The policy will contain limitations, exclusions, and termination provisions. Full details of the coverage are contained in group policy form number MSTM100C and individual policy MISTM100C (form number may vary by state). If there are any conflicts between this document and the Policy, the Policy shall govern. The Sensible Med STM is not available in all U.S. states or any other countries outside the U.S. and coverage and benefits may vary by state as well.

SMSTM201109

Sensible Med STM

Short Term Medical Insurance

Underwritten by Markel Insurance Company

The Sensible Solution to Your Immediate Medical Care Needs

The parent company, Markel Corporation, is a publicly-traded entity. Through its insurance company subsidiaries, it operates as a multi-line carrier throughout the United States and internationally. Markel Insurance Company is rated "A" (Excellent) by A.M. Best Company.

Description of Benefits

Why Short Term Medical (STM)?

Circumstances in life may have caused you to lose your health insurance. Unexpected illnesses and accidents happen every day, so don't put your financial future at risk if you can purchase short term medical insurance, until permanent insurance is available for you.

That's why Health Insurance Innovation's Sensible Med Short Term Medical (STM) is the affordable solution right for you. Sensible Med STM is issued for a pre-determined length of coverage, up to a Lifetime Maximum of $1,000,000 per Covered Person. You can select from a wide range of deductible and coinsurance options to tailor a plan to fit your lifestyle needs and budget!

How do I figure out what I need and where do I start?

First, you select your Coverage Period:

- **Single Payment**
  This option is ideal if you know the exact number of days you need coverage. The minimum number of days you may apply for coverage is 30 days, the maximum is 180 days. You pay now for the number of days you will need STM coverage. We accept payment by Visa, MasterCard or Bank Draft.

- **Monthly Pay**
  This is ideal if you are unsure how long coverage is needed. This "pay as you go" option gives you the flexibility to continue coverage for as long as it's needed or simply stop payments and discontinue the plan once your temporary need ends you can select coverage up to 6 months. We accept automatic monthly payments by Visa, MasterCard or Bank Draft.

Then, based on your lifestyle needs and budget, you select one from each of the following:

- **Deductible: $250, $1,000, $2,000, $3000, or $5,000**
  This is the amount of Covered Expenses that each Covered Person must pay before Coinsurance benefits are payable. (South Dakota's deductible differ from the above amounts; the options include $1,000, $2,500, $3,000 and $5,000.)

- **Coinsurance Percentage: 80/20 or 50/50**
  After the deductible is satisfied, this represents the percent of covered expenses that we pay and that you pay up to the Coinsurance Limit. (South Dakota's Coinsurance Percentage is 60/40)

- **Coinsurance Limit: $10,000**
  Once you've reached your Coinsurance Limit of $10,000, we pay 100% up to the $1,000,000 Lifetime Maximum. For example, if the coinsurance is 80/20, we pay 80% and you pay 20% for covered expenses until you have met your Coinsurance Limit. Then we pay at 100% up to the Lifetime Maximum.

When does coverage start?

You can select your insurance to be effective as early 12:01 a.m. the day following the transmission date of your application. However, you can choose a later effective date, but not to exceed 60 days from the date of transmission. All coverage is subject to approval of your application and payment of your first premium.

Description of Benefits Continued

What is Pre-Admission Certification?

This plan requires a Pre-Admission Certification by a Professional Review Organization service prior to in-patient hospitalization or surgery. You must call the service within 10 days prior an elective or non-emergency hospitalization or surgery; within 48-hours following an emergency admission, or as soon as reasonably possible if the person's medical condition prevents or delays such notification;with in 48-hours of delivery for complicated childbirth; or as soon as reasonably possible. Failure to pre-certify will result in a reduction in benefits of 50%. Pre-Admission Certification requirement varies by state.

How does Usual and Customary affect my benefits?

We may use and subscribe to a standard industry reference source that collects data and makes it available to its member companies in order to determine the amount that should be considered as Usual and Customary for services, medicines and supplies. The policy defines Usual and Customary to mean: (1) made by a Physician or supplier of services, medicines, or supplies; and (2) the customary charges made by others rendering or furnishing such services, medicines or supplies within an area in which the charge is incurred for Sickness or Injury comparable in severity and nature to the Injury or Sickness being treated. The term "area" as it would apply to any particular service, medicine or supply, means a county or such greater area as is necessary to obtain a representative cross section of level of charges. Usual and Customary amounts for services, medicines and supplies may vary by state.

Do I have the option to use any doctor or hospital?

Yes, there is no PPO or HMO Network requirement to receive full benefits. However, you can access Beechstreet PPO Network providers for medical care at negotiated prices.

Who is eligible to apply for this insurance?

Sensible Med STM is available to Med Sense Guaranteed Association members and their spouses, who are between 18 and 64 years old and their dependent unmarried children under 19 years old or under 25 if a full time student in an accredited school (This may vary by jurisdiction.); and can answer "No" to all of the questions in the application for insurance. Child-only coverage is available for ages two though eighteen.

What if I change my mind after I purchase the STM Coverage?

If for any reason you are not satisfied with your coverage, and you have not filed a claim, you may return the Certificate to us within 10 days after you receive it. We will refund any premium you paid and your STM coverage will be null and void.

What is the Pre-Existing Conditions Limitation?

We will not provide benefits for any loss caused by or resulting from, a Pre-Existing Condition. A Pre-Existing Condition is defined as any medical condition that required medical treatment, advice, consultation, or expense during the 24 months immediately before the Insured Person's Effective Date of insurance; or which produces symptoms within the 12 months immediately prior to the Insured Person's Effective Date of insurance. (The Pre-Existing Conditions Limitation varies by state.)

When does the STM coverage terminate?

Sensible Med STM will automatically terminate on the earliest of the following dates: The expiration date of your coverage; the date the Group Policy Terminates; the date the insurance under the Group Policy is discontinued; the due date of a premium payment, if is not paid by the end of the 31 day grace period; the date you become eligible for Medicare; your dependent's coverage ends when your coverage terminates or the dependent becomes eligible for Medicare; or the dependent cease to be eligible; the date you enter full-time active duty in the armed forces of any country or international organization; or the date we determine fraudulent statements or material misrepresentation have been made by you or with your knowledge in filing a claim for benefits.

Covered Medical Expenses

The following benefits are for Insured and each Covered Dependent subject to the plan Deductible, Coinsurance Percentage, Coinsurance Limit and Lifetime Maximum of $1,000,000. Benefits are limited to the Usual, Reasonable and Customary charge for each Covered Expense, in addition to any specific limits stated in the policy.

- Inpatient Hospital charges paid at the average semi-private room rate
- Miscellaneous Medical Services, doctors medical care and treatment
- Intensive or Critical Care up to three times the average semi-private room rate
- Outpatient Hospital or Emergency Room Care
- Physician services for treatment and diagnosis
- Ambulatory Surgical Center or Outpatient Hospital Surgical Facility
- Surgeon services in the hospital or ambulatory surgical center
- Assistant Surgeon services up to 20% of surgeons benefit
- Private Duty Nursing $75 per 8 hour shift Max of 90 shifts per Coverage Period
- Skilled Nursing Facility $30 per day up to a Max of 30 days per Coverage Period
- Home Health Care up to $40 per 8 hour shift Max of 40 visits per Coverage Period
- Hospice Care up to $5,000 Max per Coverage Period
- Acquired Immune Deficiency Syndrome (AIDS) up to $10,000 Maximum per Coverage Period
- Human Organ and Tissue Transplants Max up to $125,000 per Coverage Period
- Outpatient Physical Therapy Services Max of 12 visits per Coverage Period
- Colorectal Cancer Screening Max of $300 per Coverage Period
- Dental Anesthetic Services Max of $250 per Coverage Period
- Surgeon's Assistant services up to 15% of surgeons benefit
- Anesthesia services up to 20% of surgeons benefit
- X-ray exams, laboratory tests and analysis, radioactive isotope therapy, oxygen, casts, splints, crutches, braces, surgical dressings, artificial limbs or eyes, rental of medical supplies
- Ambulance Ground or Air Max Benefit of $250 per trip
- Mental or nervous disorders coverage of up to $5,000
- Blood or blood derivatives and their administration
- Mammograms and Pap Smears (Not subject to the Deductible)
- Spinal Manipulation or Adjustment Maximum of $1,000 per Coverage Period
- Inpatient prescription drugs

Note: This is a brief description of the plan benefits, which may vary by state.

Medical Expenses Not Covered

The following is a partial list of services or charges not covered by Sensible Med Short Term Medical. This is not a complete list of the Limitations and Exclusions and they may vary by state. Please see the Policy/Certificate of Insurance for detailed information about these and other Plan Limitations and Exclusions.

- Pre-Existing Conditions as defined in the policy
- Expenses that the Insured Person is not required to pay, or charges that would not have been billed if no insurance existed
- Any work related accidental bodily Injury or Sickness
- Expenses eligible for payment under automobile medical payment benefit
- Experimental or investigational services, supplies, or treatments
- Travel or travel expense, even though prescribed by a Physician
- Treatment of acne, varicose veins, sleeping disorders, obesity
- Treatment for foot conditions, bunions, corns, calluses or toenails
- Sterilization or elective reversal of surgical procedures, gender change or modification
- Services to treat infertility or cause Pregnancy, including diagnostic testing; drugs; medicines; artificial insemination; in vitro fertilization; and embryo transplants; or any condition or complication caused by or resulting from such treatment
- Routine eye examinations, eyeglasses, orthodontic or dental work
- Declared or undeclared war, participation in a riot illegal act or occupation, or an attempted felony or assault
- Injury or Sickness incurred during military service or

Medical Expenses Not Covered Continued

while on active duty Pregnancy or childbirth, except for Complications of Pregnancy
- Elective cesarean section when no complication is present, termination of a normal Pregnancy or procedure intended to prevent conception or childbirth
- Maternity and new born treatment prior to hospital discharge
- Mental Illness or Nervous Disorders, intentionally self-inflicted Injuries; suicide or attempted suicide, while sane or insane
- Learning disorders, attention deficit disorder or hyperactivity, or autism
- Alcoholism or abuse, drug addiction or abuse
- Cosmetic or reconstructive procedures, except as specifically covered
- Outpatient Prescription or Legend Drugs, or any over the counter medications or vitamins
- Experimental or investigational services
- Participation in high-risk sports, activities, or occupations such as: skydiving; scuba diving; bungee jumping; hang gliding; or ultra light gliding; traveling in or on any all terrain vehicles such as dirt bikes, snowmobiles, or go-carts; racing with any motorcycle, boat or any form of aircraft; participation in any sports for pay or profit; participation in inter-collegiate sports; and any rodeo events.
- Services or supplies furnished or provided by self or an immediate family member

Note: This is a brief description of the expenses not covered in the plan, which may vary by state.

Additional Discount Services

Health Insurance Innovations includes these services and discounts to the Sensible Med Short Term Medical Plan

Beech Street PPO Network Providers*

Sensible Med STM also provides access to one of the nations largest Preferred Provider Organizations. Beech Street Corporation has over 50 years of reliable service in the health care industry and has a network of over 400,000 respected doctors, 3,800 hospitals and over 52,000 ancillary network providers. Beech Street provides cost containment network Services, URAC accredited and NCQA certified clinical services, and health care financial specialty services. More information about Beech Street can be found at www.beechstreet.com

MedCare USA Prescription Discount Card*

4-tier and 100% of discounted price at participating pharmacies. Because it is a discount program there are no claim forms, no reimbursement procedures, no pre-existing condition exclusions, no waiting periods, no deductible, no benefit maximums. Members save an average of 15% off retail price on many brand name prescription drugs and 54% off retail price on many generic prescription drugs. This card is accepted at over 53,000 pharmacies throughout the United States, including most chains and independent pharmacies.

OUTLOOK Vision Discounts*

Significant savings for the entire family on eyeglasses, contact lenses, LASIK surgery and eye exams (at select locations where approved). Providers conveniently located throughout all 50 states. Most leading retail centers are included in the OUTLOOK Vision network and offer discounts from 10% to 50%. Discounts are given at point of purchase, no limits, no restrictions and no paperwork.

*These are not insurance benefits and are not affiliated with Markel Insurance Company or the Sensible Med Short Term Medical plan.

Med Sense Guaranteed Association Benefits

- **GymAmerica.com**

As a member, you and your family receive special pricing at GymAmerica.com.

- **Discount Hearing Service**

Your source for discounts on quality hearing aids and accessories.

- **Gateway Medicard**

In an emergency, getting vital health information to medical personnel quickly could be critical.

- **Vitamin Discount**

HealthFitLabs is an on-line/mail order company that sells only the highest-quality natural vitamins, nutritional supplements, and bath and personal care products.

- **LensCrafters Vision Club**

At LensCrafters, one hour service is just the beginning! Your member ID Card brings you your eligible family members special rates on all materials and services available at LensCrafters.

- **24-Hour Emergency Roadside Assistance**

Association Members can gain peace of mind on the road by registering for Emergency Roadside Assistance.

- **Association Travel Club**

Gulliver's Travel, an American Express Travel Services Representative, is the official agency for the Association Travel Club. Gulliver's offers competitive pricing and great service on the purchase of air travel, tours and cruises.

- **Travel Assistance Plan**

As a member, you receive the following services through the Travel Assistance Program when traveling more than one hundred (100) miles from your permanent residence.

- **HopTheShops.com**

Through a special arrangement with eGroupManager, you have preferred customer access to HopTheShops.com, a premium on-line shopping mall.

- **Child ID Card Services**

You can't be with your children all the time - especially when they go to school - but you can provide additional protection for those times they are not with you.

- **Savers Club® Book**

Everyday savings are right at your fingertips! With your membership, you can get a free copy of our popular Savers Club® Book, containing thousands of discounts.

- **Floral Discount**

Your Association membership lets you send flowers anywhere in North America from the web site or by phone. As an association member, you will receive a 40-60% discount from most retail flower shop prices.

- **Carperks Buying Network**

This program allows association members to benefit from a National Corporate Pricing Program. The Carperks dealer network has agreed to sell automobiles for a price better than their best Internet price, resulting in a price hundreds of dollars lower than the sales price of the retail sales department.

- **Hewett-Packard Computer and Digital Equipment**

As a member, you receive discounts on HP notebooks, laptops, servers, printers, digital cameras, handhelds, point-of-sale (scanners, cash registers, etc.) and more.

- **Customized Web Services**

eGroupManager provides the advantage of website development and maintenance. Members receive a 20% discount on the following services: Custom Web Design; Evaluation and Re-Design of Current Sites; Website Hosting; Consulting on Viability of Internet Projects; and Internet marketing.

- **UPS Express Delivery Services**

Improved program - featuring lower rates! Member discounts on UPS delivery services include 14-28% off Next Day Air®/Next Day Air® Saver Letter/Package and Worldwide Express℠.

- **T-Mobile Cell Phone Service**

Take advantage of special discounts on personal T-Mobile service, including rate plan, activation fee and handset discounts.

- **Office Depot Office Supplies and Furniture**

Sign up for the Office Depot program and qualify for discounts off the list price on over 16,000 items. Members report they save an average of 30% when compared to their previous office supplies provider. Buy online from the discounted member website, by phone or fax, or in the retail stores. There is FREE SHIPPING for members.

- **Car Rental Discounts**

Take advantage of affordable auto rental from Avis®, Budget®, and Dollar® Rent a Car.

Disclaimer: These are association or life style discount services and are not affiliated with Markel Insurance Company or the Sensible Med Short Term Medical plan. Med Sense Guaranteed Association membership is not required in the states of: CO, KS, MN, NH, SD, UT and WA.

SMSTM201109

Extra Care Package (Optional)

Dental Services

- Average annual savings of $1,200 per family on dental work
- Savings of 20%-50% on most dental procedures, including routine oral exams, unlimited cleaning and major work such as dentures, root canals and crowns
- Savings of 20% on orthodontics for both children and adults
- Savings of 20% on normal fees for all specialties – including endodontics, oral surgery, orthodontics, pediatric dentistry, periodontics and prosthodontics – where available

The dental care discounts are provided by Careington International Corporation.

CallMD & Medical Information

- CallMD members have 24/7 access to connect with a consulting physician or specialist
- Medical doctors available for consultation and may write a prescription for a non-narcotic or non-controlled medication at anytime day or night. There are 12 free consultations included with the membership. Thereafter there is a $35 charge per consultation.
- Family Keys: Personal data organizing software that downloads to the members' computer, allows members to record and store financial, health and other vital personal information without compromising privacy
- FileMD: A full medical history is recorded by a registered nurse which is stored via FileMD, and creates an Electronic Medical Record which gives members the convenience of releasing medical data, updating information, and storing documents
- 100% secure and HIPPA compliant

The medical information program is provided by CallMD.

Diabetic Supplies

- Durable medical equipment – 20% to 30% off retail price
- Daily living aids – 20% to 25% off retail price
- Disposable medical supplies – 20% to 40% off retail price
- Free blood glucose monitor upgrade
- Nutritional supplements – 20% to 25% off retail price

The diabetic supplies discounts are provided by Better Living Now.

Lab Services

- 10% to 80% savings on blood tests
- Access to over 3,000 certified labs nationwide

The lab discounts are provided by Direct Labs.

24-hour Nurse Line

- Access to nurse triage services via a toll-free number, 24 hours a day, seven days a week
- Access to a pre-recorded health information library consisting of over 1,100 topics
- HIPAA compliant

The nurse line program is provided by CareNet.

If you purchase the Extra Care Package, your effective date will be the first of next month.

Disclaimer: These are not insurance benefits. These are association or life style discount services and are not affiliated with Markel Insurance Company or the Sensible Short Term Medical Plan.

Sensible Med STM

Short Term Medical Insurance

Claims Processing by:
Co-ordinated Benefit Plans (CBP)
P.O. Box 21517
Eagan, MN 55121

Insured Benefits Provided By:
Markel Insurance Company
Rated "A" (Excellent) by A.M. Best
4600 Cox Road,
Glen Allen, VA 23059

Exclusively Distributed By:

Health Insurance Innovations
Partnered with Elite Re

Health Insurance Innovations
218 E. Bearss Ave. Suite 325,
Tampa, FL 33613
Ph. (877)376-5831 Fax (877)376-5832
www.Hiiquote.com

Marketed By:

while the Insured Person was insured under the Group Policy; or b) To correct the disorder of a normal bodily function if the disorder had its inception while the Insured Person was insured under the Group Policy; or c) Expenses are incurred for reconstructive breast surgery following a mastectomy due to illness occurring within the terms of the Group Policy. (20) Obesity, including any treatment, advice, consultation, medication, program or surgery recommended for reducing weight whether or not such weight reduction is recommended for reasons other than, or in addition, to, obesity; or any complication resulting from the treatment or surgery for weight reduction. (21) Care or treatment of: weak, strained or flat feet; instability or imbalance of the foot; metatarsalgia; bunions; corns; calluses; or toenails; except for charges: (i) by a Hospital during Confinement; or (ii) for the care and treatment of a metabolic or peripheral vascular disease; or (iii) for immediate repair of Injury from an Accident that occurred while the Insured Person was insured under the Group Policy. (22) Treatment related to: gender change or modification; sterilization or elective reversal of surgical procedures; breast reduction unless Medically Necessary; breast enlargement for any reason; or the treatment or testing for sexual dysfunction or inadequacies whether such condition has a physical or organic basis or origin. (23) Services or supplies of a common household use, including but not limited to: exercise cycles; air or water purifiers; air conditioners; allergenic mattresses; and blood pressure kits. (24) Charges for items or services of convenience, including but not limited to: admission kits; telephone; slippers; or homemaker services; supportive service focusing on activities of daily life such as bathing; dressing; feeding; or skin and/or bladder care; administration of oral medication or eye drops, except as specifically covered in the Group Policy. (25) Experimental or investigational service, supplies, or treatments. (26) Travel or travel expense, even though prescribed by a Physician. (27) Outpatient Prescription Drugs; medicines; vitamins (including prenatal vitamins); mineral or food supplements; or any over the counter medicines, whether or not ordered by a Physician. (28) Charges for the treatment of acne or varicosities of the veins. (29) Any Expense for the treatment of Injury or Sickness occurring while intoxicated or under the influence of alcohol, illegal drugs, hallucinogenics or narcotics unless said narcotics were prescribed by a Physician and used as recommended. "Intoxicated" and "under the influence" will have the meanings determined by the laws of the jurisdiction of the geographical region in which either the Loss or the cause occurs. (30) Charges related to transportation, except where specifically covered in the Group Policy. (31) Expenses incurred to treat complications resulting from any treatment or care of conditions that are not covered under the Group Policy. (32) Expenses related to diagnosing, testing for, or treating a sleeping disorder. (33) Testing, diagnosis or treatment for or related to learning disabilities; attention deficit disorder; hyperactivity; autism; or related conditions.

This is not a complete list of the limitations and exclusions. Please see the detailed list in policy certificate you will receive when you purchase Short Term Medical Insurance. Exclusions and Limitations may vary by state.

When does coverage begin?

If you submit the application form and initial payment via:

Internet or facsimile, the earliest date that coverage can begin (if approved by Markel) is 12:01 a.m. on the day after SASid receives the completed application form and valid electronic payment information. A later effective date may be requested, but no more than 30 days following the application date. Note – payment must be made by automatic bank draft or MasterCard / VISA.

U.S. Mail, the earliest date that coverage can begin (if approved by Markel) is 12:01 a.m. on the day after the postmark date stamped by the U.S.P.S. on the envelope in which SASid receives the completed application form and payment for the total amount due. If the U.S.P.S. postmark date is not legible or present, the earliest date that coverage can begin is the day after the completed application form and payment for the correct plan cost are received by SASid. A later effective date may be requested, but no more than 30 days following the application date.

Do I Need Precertification?

Pre-admission certification prior to eligible in-patient hospitalization or surgery by the covered individual within 48 hours is required. This is not a guarantee of benefits. Failure to precertify will result in a benefit reduction of 50%. Call 1-800-874-2378 for precertification.

Payment Options

Single Payment – If you know the exact length of time you'll need this coverage and prefer to make one single payment for the entire Benefit Period, this payment option is ideal. Simply enter the exact total number of days you need coverage and pay for that Benefit Period (30 day minimum / 6 month maximum).

Monthly Payment – If you are unsure how long you'll need this coverage or prefer the convenience of making monthly installment payments, this option is ideal. Each monthly payment is for 30 days of coverage, up to the 6 months maximum Benefit Period. If your need for this coverage ceases before your Benefit Period expires, simply contact our office via email at info@smartstm.com or visit our Online Customer Service Center at www.smartstm.com.

Payment Methods

Personal Check: You will receive payment coupons with your Policy or Certificate. The 1st payment coupon will reflect a credit equal to your initial payment. Subsequent monthly payments, must be received by SASid on or before the payment due dates shown on payment coupons.

Automatic Bank Draft or Credit Card: Your initial payment and subsequent monthly payments will be automatically debited (on or immediately following the payment due dates) from your bank account or your MasterCard / VISA that is identified on the Electronic Payment Authorization form. If you wish to discontinue coverage before your Benefit Period expires, simply mail or fax your written request for termination to SASid and we will discontinue future automated electronic debits.

Note: 5 days advance written and signed notice from the Primary Insured is required to ensure future credit card debits are discontinued.

Money Back Guarantee

If you are not satisfied that this coverage will meet your insurance needs, simply return the Policy or Certificate with your written and signed request for cancellation within 10 days after you receive it. Coverage will be canceled as of the effective date and you will receive a full premium refund of your initial payment – no questions asked!

Note: the application and administration fees are non refundable.Underwritten by Markel Insurance Company.

Markel Insurance Company:
"Driven by Tradition…Powered by People"

The parent company, Markel Corporation, is a publicly-traded entity. Through its insurance company subsidiaries, it operates as a multi-line carrier throughout the United States and internationally.

Much of the company's success is the result of the dedicated work of the thousands of Markel associates who have powered the company and made its values and traditions tangible for customers. This is the "Markel Style."

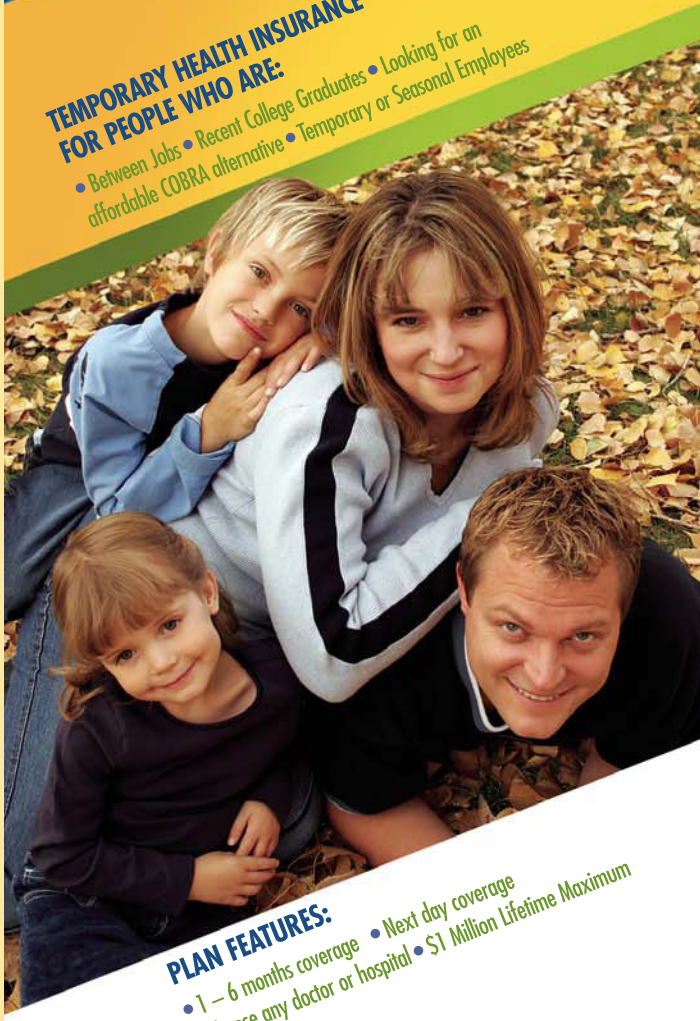
Administration:
- Customer & Agent service and billing is handled by SASid. 462 Midland Rd., Janesville, WI 53545. Toll-Free: 1-800-279-2290
- Customer Claims are administered by International Funding Ltd. P.O. Box 2478, Madison, WI 53701 Toll-Free: 1-800-610-1920

Current Ratings for Markel Insurance Company	
A.M. Best Company, Inc.	"A Excellent" – Category XII
Standard & Poors Claims Paying Ability	"A-" (Strong)
Duff & Phelps' Claims Paying Ability	"A" (High)

MARKEL INSURANCE COMPANY

SMART
Short Term Medical

TEMPORARY HEALTH INSURANCE FOR PEOPLE WHO ARE:
- Between Jobs
- Recent College Graduates
- Looking for an affordable COBRA alternative
- Temporary or Seasonal Employees



PLAN FEATURES:
- 1 – 6 months coverage
- Next day coverage
- Choose any doctor or hospital
- $1 Million Lifetime Maximum

INSURED BY:

MARKEL INSURANCE COMPANY

Protect yourself and your family from unexpected illnesses or accidents.

A simple accident like a broken bone or torn muscle can cost thousands of dollars. The *unexpected does happen* and if it does you will be thankful that you purchased Smart STM. *Don't be without health insurance!*

Short Term Medical insurance is designed for people who need temporary health insurance coverage for up to 6 months. It has never been easier or faster to get health insurance. So whether you are:

- Between jobs
- Looking for an affordable COBRA insurance alternative
- A recent college graduate
- A temporary or seasonal employee
- Unemployed or laid-off
- Waiting for other health insurance
- Have any temporary need of health coverage

In 3 simple steps you can have affordable health insurance coverage as soon as tomorrow!

3 Simple Steps To Affordable Insurance

1 Select Plan/Rate → 2 Complete Application → 3 Send Payment

1) Select a plan/rate that meets your needs and budget.
2) Complete a simple 5 minute application.
3) Send in your payment and application.
   Coverage can be issued as soon as tomorrow!

Register Online!

Plan Highlights:

- Freedom to choose your own doctors and hospitals
- $1 Million Lifetime Maximum Coverage
- In-Hospital and Out-patient benefits
- Physician Services - diagnosis and treatment
- Surgery in a Hospital or Ambulatory Surgical Center
- Intensive Care
- X-Ray and Laboratory
- Ambulance Services
- Spinal Manipulation/Adjustment
- Mammography, Pap smear and screens

* Benefits vary by state. Refer to your coverage document for specific terms and conditions.

Here's How Short Term Medical Works:

Choose the plan that best fits your needs and budget:

- Deductible options:
  $250, $500, $1,000, $2,000, $2,500, $3,000 or $5,000
- Coinsurance options:
  80/20 of $10,000 or 50/50 of $10,000
  100% (only available on deductibles of $1,000 and up)
- Length of Coverage options:
  1 – 3, 1 – 6 months of coverage

Benefits are paid as follows:

FIRST	**You satisfy your deductible:** $250, $500, $1,000, $2,000, $2,500, $3,000 or $5,000
THEN	We pay **100%**, **80%** or **50%** of the next **$10,000** of covered expenses
100%	We pay **100%** of remaining covered expenses up to the **$1 Million** Lifetime Maximum

Who's Eligible for Short Term Medical?

You and your spouse under age 65 (and not eligible for Medicare) and you and your spouse's unmarried dependent children under age 19 (or under age 25 if a full-time student) who have a social security number and can answer "No" to the five health questions on the application.

Child Only Directions

Children age 19 and over should apply separately. Child-only coverage is available for ages 2 through 18. The application must be completed and signed by the parent or legal guardian.

Child(ren) alone can apply and are to use the 0-24 premium rate (male or female, based on their gender) for the youngest child; and the per child rate for each of the child siblings to be insured. The minimum age for a child only coverage is 2 years old. The application must be completed and signed by the parent or legal guardian.

Exclusions & Limitations

We will not pay benefits, and charges will not accrue toward any Deductible Amount, for Expenses incurred as a result, directly or indirectly, of any of the following: (1) [Pre-Existing Conditions, as defined (2) Expenses that the Insured Person is not required to pay, or those charges that would not have been billed if no insurance existed. (3) Charges for custodial maintenance; pre-marital screenings or exams; routine services for general physical examinations; physical examinations that are required by third parties; diagnostics, screenings and research; preventative or prophylactic care; and immunizations, unless specifically noted in the Group Policy. (4) Medical Expenses that are eligible for payment under an automobile medical payment benefit, regardless of fault. (5) Injury or Sickness resulting from war, either declared or undeclared; riot or any act incidental to war or riot; while committing or attempting to commit felony; intentionally self-inflicted Injuries; suicide or attempted suicide, while sane or insane. (6) Injury or Sickness incurred during military service or while on active duty. Upon written notice to Us of entry into active duty, any unused premium will be returned to the Insured Person on a pro-rated basis. (7) Substance Abuse Treatment unless specifically provided by State Mandated benefits. (8) Charges incurred by an insured Dependent who is a newborn child not yet discharged from the Hospital, unless the charges are necessarily incurred as the result of, and to treat, premature birth, congenital Injury or Sickness, or Injury or Sickness sustained during or after birth. (9) Charges related to elective cesarean section when no complication is present or voluntary termination of a normal Pregnancy including, but not limited to, the cost of any drug, contraceptive, supply, treatment, or procedure intended to prevent conception or childbirth. (10) Any work-related accidental bodily Injury or Sickness. (11) Routine charges for the care and/or treatment of a normal Pregnancy or childbirth with the exception of those Expenses related to a Complication of Pregnancy as defined in the Group Policy. (12) Any services, supplies or treatment furnished by the Insured Person, an Insured Person's Immediate Family, or Employer. (13) Services or supplies rendered to a transplant donor of any organ or bodily element or the acquisition cost of any organ or bodily element. (14) Services related to or for the purpose of treating infertility or causing Pregnancy, including but not limited to, diagnostic testing; drugs; medicines; artificial insemination; in vitro fertilization; and embryo transplants; or any condition or complication caused by or resulting from such treatment. (15) Participation in high-risk sports, activities, or occupations such as: skydiving; scuba diving; bungee jumping; hang gliding; or ultra light gliding; traveling in or on any all terrain vehicles such as, but not limited to: dirt bikes, all terrain vehicles, snowmobiles, or go-carts; racing with any motorcycle, boat or any form of aircraft; participation in any sports for pay or profit; participation in intercollegiate sports; and any rodeo events. (16) Charges that do not meet the definition or are not specifically identified under the Group Policy as Eligible Expenses, including amounts in excess of the Usual and Customary charges for the geographic area in which the charges are incurred. (17) Charges determined to be for educational purposes or charges that may be provided through an educational program or facility. (18) Voluntary inhalation or ingestion of any gas, poison or poisonous substance. (19) Cosmetic, reconstructive or plastic surgery unless: a) As a result of an Injury that occurred

SERFF Tracking Number:	*MRKC-128177674*	*State:*	*District of Columbia*
Filing Company:	*Markel Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*MSTM200-DC (11/11)*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*Short Term Medical Amendatory Endorsement*		
Project Name/Number:	*MSTM200-DC (11/11)/MSTM200-DC (11/11)*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
04/03/2012	Supporting Document	Response Cover Letter	05/04/2012	Cover Letter- Response to Objection 021512.pdf (Superceded)

MARKEL

April 3, 2012

District of Columbia Department of Insurance
Life & Health Division
810 First Street, NE, Suite 701
Washington, DC 20002

Dear Monica Myers,

Please see our response to your objection on 02/15/12 regarding filing MRKC-127663136.

Your questions were as follows **(answers in bold)**:

1. Is the product "non-renewable" or is it "not guarantee renewable". If it is " not guaranteed renewable", then please list all of the circumstances for which it would not be renewed. **This product is non-renewable.**
2. To what associations in DC do you intend to market this product? Please define a "bonafide association". Where would the premium taxes be paid? **The associations we will market this product to at this time are: Association of United Internet Consumers; and Med Sense Guaranteed Association. "Bona fide association" means, an association which-- (A) has been actively in existence for at least 5 years; (B) has been formed and maintained in good faith for purposes other than obtaining insurance; (C) does not condition membership in the association on any health status-related factor relating to an individual; (D) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member); (E) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and (F) meets such additional requirements as may be imposed under State law. The premium taxes would be paid to the agent during the enrollment process.**
3. In Table 3 of your Rate Manual. Please include the Medicare Payment Levels for which you are basing the benefits and rates. **Please see our attachments regarding RBRVS and DRG Medicare Payment level exhibits.**
4. Please justify the 10% underwriting profit provision. It seems a bit high. **Please see the attached 2010 Calculation of the Profit Provision for Accident and Health.**
5. Please justify the 1% Finder's Fee. What is a Finder's Fee? **A Finder's Fee is a fee paid to a reinsurance intermediary that was responsible for initially bringing us the business.**
6. How do you determine Usual & Customary fees? What organization(s) do you reference for Usual & Customary fees? Do you apply any factors to the reference organization's determination of Usual & Customary fees? **We currently use FAIR**

Health MDR/UCR and Context 4 Healthcare at the 80th percentile for non-RBRVS claims payments. For RBRVS claims payments Context 4 Healthcare is also used.

Sincerely,

Katie J Savino

Katie Savino
Regulatory Compliance Specialist

Enclosure: